FOLKETINGETS OMBUDSMAND

Monitoring Activities 2018

Extracts from the Annual Report of the Danish Parliamentary Ombudsman

Preface

This publication contains extracts from the 2018 Annual Report of the Danish Parliamentary Ombudsman of the material relating specifically to the Ombudsman's monitoring activities.

The extracted material on pages 34-62 is unchanged from the Annual Report, and the original pagination has been maintained.

This is followed by summaries of statements and extracts from news relating specifically to the Ombudsman's monitoring activities.

The 2018 Annual Report of the Danish Parliamentary Ombudsman can be read in full on www.ombudsmanden.dk or obtained in book form from the Ombudsman's office.

Monitoring activities 2018

Monitoring activities – adults and children

Where: The Ombudsman carries out monitoring visits to public and private institutions, especially institutions where persons are or may be deprived of their liberty, such as prisons, social care institutions and psychiatric wards.

Why: The purpose of the Ombudsman's monitoring visits is to help ensure that daytime users of and residents in institutions are treated with dignity and respect and in compliance with their rights.

The monitoring visits are carried out in accordance with the Ombudsman Act as well as the Optional Protocol to the UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). Pursuant to this Protocol, the Ombudsman has been appointed 'national preventive mechanism'. The task is carried out in collaboration with DIGNITY – Danish Institute Against Torture and the Danish Institute for Human Rights, which contribute with medical and human rights expertise.

The Ombudsman has a special responsibility to protect the rights of children under the UN Convention on the Rights of the Child etc.

How: During monitoring visits, the Ombudsman often gives recommendations to the institutions. Recommendations are typically aimed at improving conditions for users of the institutions and in this connection also at bringing conditions into line with the rules. Recommendations may also be aimed at preventing, for instance, degrading treatment.

Monitoring visits may also cause the Ombudsman to open investigations of general problems.

Who: The Monitoring Department carries out monitoring visits to institutions for adults, whereas the Ombudsman's Children's Division carries out monitoring visits to institutions for children. The Ombudsman's special advisor on children's issues participates in monitoring visits to institutions for children and, if deemed relevant, in visits to institutions for adults.

Usually a medical doctor from DIGNITY – Danish Institute Against Torture participates in the visits, and often a human rights expert from the Danish Institute for Human Rights (IMR) will participate as well.

Monitoring activities – adults

Theme for 2018

Exclusion of inmates from association with other inmates in Prison and Probation Service institutions
Normally, it is possible for inmates in state and local prisons to spend time together, but an inmate may be excluded from association with other inmates, among other things to prevent escape, criminal offences or violent behaviour or in order to uphold safety in the institution.

Inmates may also choose voluntary exclusion from association. This often happens if an inmate feels threatened by fellow inmates.

An inmate who is excluded from association is placed in solitary confinement, and isolation may have adverse psychological effects. It is therefore important that the duration of exclusions is as short as possible and that exclusions are carried out as gently as possible.

As part of the theme for 2018, the Ombudsman's monitoring teams visited four closed prisons, four open prisons and nine local prisons, focusing especially on

- the specific conditions for inmates excluded from association
- the quality of reports on exclusions from association

Examples of important conclusions
- Exclusions from association in Prison and Probation Service institutions are generally carried out in accordance with the rules, but there is room for improvement of the documentation.
- There is no general guide for staff in Prison and Probation Service institutions on how to handle *voluntary* exclusions.
- The existing guide on *forced* exclusions from association does not cover all relevant topics.

The Ombudsman generally recommends
- that state and local prisons increase their focus on precise and adequate documentation in reports and weekly records concerning exclusions from association and ensure regular quality control
- that state and local prisons and the Department of Prisons and Probation monitor developments in the use of forced and voluntary exclusion from association and analyse the causes of the developments

Please see the Ombudsman's specific recommendations (extracts) in the table on pages 38-45.

Reports on the themes for our monitoring visits in recent years can be found at www.ombudsmanden.dk by clicking the small globe icon at the top of the site, selecting 'English' and choosing the heading 'About the Ombudsman' and then 'Publications'.

Cases concluded in 2018 in relation to monitoring activities

29 cases about suicide attempts, deaths etc. in Prison and Probation Service institutions or among persons in police custody. *Three of the cases resulted in criticism.*

Further, **six** cases were opened on the Ombudsman's own initiative (**four** of which in direct continuation of monitoring visits). *Two of the cases resulted in criticism or formal or informal recommendations.*

Selected investigations

Better prevention of suicides: In an immigration detention centre, there had been several incidents within a few years of detainees trying to commit suicide by hanging themselves from exposed pipes on the ceilings. The Ombudsman pointed out this trend to the authorities in charge. The authorities replied that they would ensure that the pipes were hidden. (News story published on 1 June 2018).

Tolerated residence is stressful: The Ombudsman investigated the conditions for persons with tolerated residence status who were required to reside in a departure centre and in fact resided there. His conclusion was that the overall conditions for this category of persons were to be regarded as very stressful and as severely restricting even basic aspects of living. However, the Ombudsman was of the opinion that the general conditions for these persons did not contravene, for instance, the European Convention on Human Rights. (Case No. 2018-18 and news story published on 29 May 2018).

Information available in cases about suicides/suicide attempts by inmates was inadequate: In three cases about suicides/suicide attempts in the same local prison, the Ombudsman looked into, among other things, whether staff ought to have paid more attention to the inmates prior to the incidents and, for instance, should have checked on them more frequently or called in a doctor. The Ombudsman had no grounds for repudiating the authorities' assessment of the need for checking up on inmates or calling in a doctor, but in two of the cases, the Ombudsman criticised the absence of adequate information about the facts of the cases.

The Ombudsman called for increased awareness in relation to use of pepper spray: Based on a specific case, the Ombudsman urged the Prison and Probation Service to consider generally whether there was a need for taking steps to ensure that the rules are observed when pepper spray is used against inmates in Prison and Probation Service institutions. The Ombudsman also pointed out the importance of adequate documentation in such cases in order that the legality of the use of force can actually be verified. (News story published on 4 January 2019).

Where did we go in 2018?

When	Where	What	With whom did we speak?		Who also participated?[1]		
			Users[2]	Relatives etc.[3]	DIGNITY	IMR	
	30 visits in total		**259 talks**	**21 talks**	**29 visits**	**12 visits**	
22 Jan.	'Psykiatrisk Center Glostrup', Hvidovre Unit	Two bed units for general psychiatric patients	4	3	✓	✓	
25 Jan.	'Psykiatrisk Center Amager'	Two 24-hour intensive psychiatric care units for general psychiatric patients	7	2	✓	✓	
29 Jan.	'Kofoedsminde', Rødby	Five secure sections in a special institution for mentally deficient persons who have been sentenced to placement in an institution	8	0	✓	✓	
8 Feb.	'Psykiatrisk Center Ballerup'	Two 24-hour intensive psychiatric care units particularly for general psychiatric patients	5	5	✓		
16 Feb.	'Køge Arrest'	Local prison particularly for persons remanded in custody during investigation of their case	9	0	✓		
20 to 21 Feb.	'Herstedvester Fængsel', Albertslund	Closed special prison particularly for persons serving time and needing psychiatric, psychological and/or sexological diagnostic evaluation and treatment	37	1	✓	✓	
23 Feb.	'Halsebyvænge', Korsør	Unit in municipal social residential facility particularly for mentally deficient persons with a conviction	2	0	✓	✓	

1) The Ombudsman collaborates with DIGNITY – Danish Institute Against Torture and the Danish Institute for Human Rights (IMR) on monitoring activities. Among other things, they participate in a number of monitoring visits.
2) Number of inmates, residents, patients etc. with whom the visiting teams had talks.
3) Number of relatives, guardians (including social security guardians), patient advisors etc. with whom the visiting teams had talks.

	Selected recommendations[4]
	Visits concluded with recommendations: 26 **Visits concluded without comments: 4** **Not concluded at the time of going to press: 0**
	The monitoring visit did not give rise to recommendations
	• Record and analyse duration of restraints
	• Draw up guidelines on how to handle and prevent violence and threats among residents (anti-violence policy) • Ensure current instructions on how to handle medicines and inadvertent incidents etc. are available • Ensure each healthcare worker is given individual access to the Shared Medicine Card
	The monitoring visit did not give rise to recommendations
	• Increase focus on precise and adequate documentation in reports and weekly records concerning exclusions from association and ensure regular quality control • Improve documentation in reports on placements in security cells • Brief inmates after searches of their cells
	• Increase focus on precise and adequate documentation in reports and weekly records concerning exclusions from association and ensure regular quality control
	• Draw up directions on use of force and arrange training of staff • Prepare written information about rules of conduct etc. • Update and extend medicine directions so that they meet applicable requirements • Ensure procedures are in place for clearing out the medicine cabinet • Improve the availability of activities for residents to bring it up to the level of comparable social residential facilities

4) The table contains selected, abbreviated recommendations. The full recommendations can be found (in Danish only) at www.ombudsmanden.dk, where concluding letters on monitoring visits are published on an ongoing basis.

Where did we go in 2018?

When	Where	What	With whom did we speak?		Who also participated?[1]	
			Users[2]	Relatives etc.[3]	DIGNITY	IMR
27 Feb.	'Københavns Fængsler, Politigårdens Fængsel'	Closed prison section mainly for 'negatively strong' arrestees. The monitoring visit concerned the conditions for a remand prisoner who had been excluded from association for a long time	0[5]	0	✓	✓
5 Mar.	'Kalundborg Arrest' (**partly announced** visit)	Local prison particularly for persons remanded in custody during investigation of their case	9	0	✓	✓
14 Mar.	'Holstebro Arrest'	Local prison particularly for persons remanded in custody during investigation of their case	8	0	✓	
15 Mar.	'Regionspsykiatrien Midt', Viborg	Two bed units for forensic psychiatric patients	11	3	✓	✓
21 Mar.	'Center Bakkehuset', Videbæk	Two units in municipal social residential facility for adults needing specialised support 24 hours a day	0[6]	2	✓	
22 Mar.	'Sdr. Omme Fængsel' (**partly announced** visit)	Open prison particularly for persons serving time	4	0	✓	✓
5 Apr.	'Københavns Fængsler', Vestre Fængsel	Local prison particularly for persons remanded in custody during investigation of their case	5	0	✓	✓
10 Apr.	'Kragskovhede Fængsel', Jerup	Open prison with a closed prison section, particularly for persons serving time	10	0	✓	

5) The inmate did not wish to speak with the visiting team.
6) The users' level of function made talks impossible.

	Selected recommendations[4]
	• Try to extend the inmate's time out of the cell with visits to the training facilities when deemed justifiable on safety grounds
	• Draw up medicine directions and train staff in the directions • Ensure unused medicines are handled in accordance with directions
	• Draw up directions on abstinence treatment and monitoring of inmates with withdrawal symptoms • Ensure unused medicines are handled in accordance with directions • Ensure inmates do not perceive the use of a urine bottle at night as compulsory
	• Ensure records of use of coercion contain specific information about grounds etc. • Draw up guidelines on how to handle and prevent violence and threats among patients (anti-violence policy) • Harmonise house rules
	• Draw up guidelines on use of force and ensure training of staff with focus on gentle handling • Conclude a written agreement on the terms when a private security and guard services company is used • Increase focus on handling of medicines and healthcare documentation
	• Increase focus on precise and adequate documentation in reports and weekly records concerning exclusions from association and ensure regular quality control • Look into whether practice regarding sale of non-prescription medicines meets applicable requirements within the field
	• Ensure systematic monitoring of inmates placed in disciplinary cell • Amend internal guidelines on exclusions from association to conform with applicable rules
	• Increase focus on precise and adequate documentation in reports and weekly records concerning exclusions from association and ensure regular quality control • Monitor and analyse developments in number of exclusions from association • Tighten up on labelling of medicines etc.

Where did we go in 2018?

When	Where	What	With whom did we speak?		Who also participated?[1]	
			Users[2]	Relatives etc.[3]	DIGNITY	IMR
11 Apr.	'Ringkøbing Arrest'	Local prison particularly for persons remanded in custody during investigation of their case	7	0	✓	
17 Apr.	'Esbjerg Arrest'	Local prison particularly for persons remanded in custody during investigation of their case	5	0	✓	
18 Apr.	The police detention facility in Esbjerg (**unannounced** visit)	Police detention facility particularly for persons who are unable to take care of themselves due to intoxication and who have been encountered by the police in a dangerous situation	0[7]	0	✓	
24 Apr.	'Helsingør Arrest'	Local prison particularly for persons remanded in custody during investigation of their case	9	0	✓	
25 Apr.	The police detention facility in Elsinore (**unannounced** visit)	Police detention facility especially for persons who are unable to take care of themselves due to intoxication and who have been encountered by the police in a dangerous situation	0[7]	0	✓	
8 May	'Østruplund', Otterup	Three units in a regional social residential facility for mentally deficient adults with a conviction or problematic behaviour	6	2	✓	
9 May	'Odense Arrest' (**unannounced** visit)	Local prison particularly for persons remanded in custody during investigation of their case	10	0	✓	

7) There were no persons placed in the detention facility at the time of the visit.

	Selected recommendations[4]
	• Update medicine directions to meet applicable rules • Draw up directions on abstinence treatment and monitoring of inmates with withdrawal symptoms • Ensure correct labelling and storage of medicines for inmates • Handle unused medicines in accordance with directions and ensure procedures are in place for clearing out the medicine cabinet
	• Increase focus on precise and adequate documentation in reports and weekly records concerning exclusions from association and ensure regular quality control • Ensure unambiguity and clear agreements in relation to cooperation between healthcare workers, including precise framework delegation from doctor to nurse and updating of directions • Ensure inmates can have private telephone conversations that cannot be overheard by fellow inmates
	The monitoring visit did not give rise to recommendations
	• Ensure prison's healthcare staff are informed about exclusions from association • Ensure reports on temporary exclusions from association meet applicable requirements • Rewrite medicine directions and make them more specific • Ensure adequate labelling of medicines for the individual inmates etc.
	• Introduce procedures for self-checking smoke alarm and electronic equipment in facility • Increase awareness of adequate completion of detention reports • Ensure persons placed in facility are monitored in accordance with applicable rules
	• Extend existing directions on use of force with information about the special rules applicable for convicted persons in social residential facilities • Draw up a policy on violence and threats among residents, including sexual abuse, and guidelines on reporting incidents involving violence and threats to the police
	• Increase focus on precise and adequate documentation in reports and weekly records concerning exclusions from association and ensure regular quality control • Be aware of how staff address inmates – also of remembering to knock before opening the door to a cell • Implement request forms with a copy to the inmate to avoid complaints, doubts etc. • Ensure focus on correct handling of medicines, on offering new inmates a medical examination etc.

Where did we go in 2018?

When	Where	What	With whom did we speak?		Who also participated?[1]	
			Users[2]	Relatives etc.[3]	DIGNITY	IMR
14 to 15 May	'Nyborg Fængsel'	Closed prison with, among others, a special section for 'negatively strong' arrestees	32	0	✓	✓
16 May	'Fonden Station Vest', Brovst	Private social residential facility for adults with impaired mental functioning and an extensive need for support	3	2	✓	
17 May	'Botilbud På Tværs', Farsø	Private social residential facility for adults with major behaviour disorders, including persons sentenced to placement in an institution	5	0		
7 to 8 June	'Nr. Snede Fængsel'	Open prison with closed sections, including disciplinary and solitary confinement sections	26	0	✓	
13 June	'Psykiatrien' – Aalborg University Hospital	Two bed units for forensic psychiatric patients	8	1	✓	
14 June	'Aalborg Arrest'	Local prison particularly for persons remanded in custody during investigation of their case	5	0	✓	
6 Sep.	'Enner Mark Fængsel', Horsens	Prison section (in closed prison) particularly for persons remanded in custody during investigation of their case and high-security section	10	0	✓	
26 Sep.	'Søbysøgård Fængsel', Årslev	Open prison with closed section, particularly for persons serving time	14	0	✓	✓

	Selected recommendations[4]
	• Increase focus on precise and adequate documentation in reports on exclusions from association • Draw up a policy on how to handle and prevent violence and threats among inmates (anti-violence policy) • Make current framework delegation from doctor available to staff (instead of outdated directions)
	• Draw up directions on use of force • Draw up directions on staff assistance with administration of residents' finances • Adjust existing medicine directions to meet applicable requirements
	The monitoring visit did not give rise to recommendations
	• Increase focus on precise and adequate documentation in reports on exclusions from association, including healthcare workers' contact with inmates excluded from association • Management focus on overall developments in number, duration etc. of exclusions • Improve written directions from doctor to nurses and increase focus on correct handling of medicines • Look into how cooperation with psychiatric sector and outpatient addiction treatment facility can be strengthened
	• Increase focus on correct record-keeping of use of coercion and observance of rules on medical attention and debriefings after coercion • Record incidents of violence and threats among patients for the purpose of documentation, knowledge and learning • Draw up guidelines on how to handle and prevent violence and threats among inmates (anti-violence policy) • Give guidance to patients about the characteristics of 'timeouts' etc.
	• Increase focus on precise and adequate documentation in reports on exclusions from association and ensure regular quality control • Remember to knock before opening the door to a cell • Respond as quickly as possible to calls at night from inmates wishing to use the toilet • Ensure in cooperation with the doctor that directions on framework delegation and other relevant directions in relation to healthcare provision are drawn up
	• Increase focus on precise and adequate documentation in reports and weekly records concerning exclusions from association and ensure regular quality control
	• Increase focus on precise and adequate documentation in reports and weekly records concerning exclusions from association and ensure regular quality control • Ensure that, in open sections, urine bottles are used at night only by voluntary agreement with inmates and that inmates are informed about this • Draw up directions on handing out non-prescription medicines and on handling of unused medicines

Monitoring activities – children

Theme for 2018

Use of force and other interventions in asylum centres for children and in private accommodation facilities for, among others, children and young people with an asylum background

The theme of the monitoring visits carried out by the Ombudsman's Children's Division in 2018 focused on children and young people with an asylum background. The theme encompassed children and young people who were either asylum seekers or rejected asylum seekers or had been granted a residence permit.

The children and young people were mostly unaccompanied underage foreign nationals.

As part of the theme, the Ombudsman's visiting teams visited five private accommodation facilities and four asylum centres for children. The visits focused especially on

- use of physical force
- practice regarding notification of municipalities about children and young people who may be in need of special support

Examples of important conclusions

- There is general awareness of ensuring that the well-being of the child or the young person is given primary consideration, also in connection with use of force, and of the duty to notify the municipality about children and young people who may need special support.
- In several asylum centres and accommodation facilities, there is inadequate knowledge of the legislation on use of force.
- Many asylum centres and accommodation facilities face challenges with children and young people who have lost hope due to being refused residence, who abuse substances or have street-oriented behaviour or who disappear.

The Ombudsman generally recommends

- that children's asylum centres and accommodation facilities ensure
  - that staff are familiar with the legislation on use of force
  - that guidelines on use of force are in compliance with legislation
  - that children, young people, parents and personal representatives are informed about their rights in relation to use of force when children and young people arrive
- that accommodation facilities ensure that medicines are handled in accordance with applicable rules

Please see the Ombudsman's specific recommendations (extracts) in the table on pages 48-51.

Reports on the themes for our monitoring visits in recent years can be found at www.ombudsmanden.dk by clicking the small globe icon at the top of the site, selecting 'English' and choosing the heading 'About the Ombudsman' and then 'Publications'.

Cases concluded in 2018 in relation to monitoring activities

Nine cases were opened by the Ombudsman on his own initiative (**three** of which in direct continuation of monitoring visits). *Two of the cases resulted in criticism and informal recommendations, respectively.*

Selected investigations

Conditions to be improved for 15- to 17-year-old inmates in local and state prisons: Based on monitoring visits to two local prisons, the Ombudsman raised a number of questions regarding the treatment of inmates aged 15 to 17 years. The authorities provided information about new initiatives aimed at improving conditions for young people detained in local and state prisons. For instance, the authorities intended to introduce rules to ensure that young people serving time are offered schooling which bears comparison with that provided by primary and lower secondary schools. (News story published on 4 July 2018).

A boy was illegally monitored in an accommodation facility: An accommodation facility had, among other things, taken screenshots of the mobile phone of a boy placed in the facility, written down his conversations with his former foster family and forwarded the information to the municipality. No decision had been made by the municipality's committee for children and young people that the boy's communication was to be monitored. The Ombudsman criticised the illegal monitoring of the boy's communication and notified Parliament's Legal Affairs Committee, the Minister for Children and Social Affairs and the municipal council of the case. (Case No. 2018-26 and news story published on 5 July 2018).

Children and young people placed in care outside their home are entitled to be taught in a school: Placement facilities without an in-house school are not permitted to provide the schooling for children and young people placed in care. Instead, these children and young people must be taught in, for instance, an in-house school of another facility or a primary and lower secondary school, possibly in a special needs class or school. This was the Ombudsman's conclusion following an investigation based on the schooling of a 14-year-old. On that basis, the Ministry of Education would send a letter to all municipalities about schooling in daytime care facilities and placement facilities without in-house schools. (News story published on 4 October 2018).

Rejected asylum children in Departure Centre Sjælsmark living under difficult conditions: Following two unannounced monitoring visits, the Ombudsman concluded that the conditions for children in Departure Centre Sjælsmark were liable to make their childhood substantially more difficult and to restrict their possibilities of a natural development and self-realisation considerably. At the same time, it was the Ombudsman's assessment that their conditions could not generally be presumed to violate international conventions, including the UN Convention on the Rights of the Child. (Case No. 2018-39 and news stories published on 20 December 2018 and 8 January 2019).

Where did we go in 2018?

When	Where	What	With whom did we speak?		Who also participated?[1]		
			Users[2]	Relatives etc.[3]	DIGNITY	IMR	
	9 visits in total		**44 talks**	**22 talks**	**4 visits**	**2 visits**	
31 Jan. to 1 Feb.	'Børnecenter Tønder'	Asylum centre for unaccompanied underage foreign nationals	5	2			
5 to 6 Feb.	'Alhambra', Ballerup	Private accommodation facility for, among others, children and young people with an asylum background	6	2		✓	
5 to 6 Mar.	'Fonden Hugin & Munin', Aalestrup	Private accommodation facility for, among others, children and young people with an asylum background	4	3			
5 and 7 Mar.	'Ask4US ApS', Farsø	Special placement facility for unaccompanied underage foreign nationals with behaviour for which an ordinary asylum centre for minors does not have the capacity	7	4	✓		
10 to 11 Apr.	'Børnecenter Gribskov', Græsted	Asylum centre for unaccompanied underage foreign nationals including foreign nationals under 16 with street-oriented behaviour	8	1	✓		

1) The Ombudsman collaborates with DIGNITY – Danish Institute Against Torture and the Danish Institute for Human Rights (IMR) on monitoring activities. Among other things, they participate in a number of monitoring visits.
2) Number of children and young people with whom the visiting teams had talks.
3) Number of relatives, personal representatives and guardians with whom the visiting teams had talks.

	Selected recommendations etc.[4]
	Visits concluded with recommendations: 6 **Visits concluded without comments: 0** **Not concluded at the time of going to press: 3**
	• Ensure staff are familiar with the rules of the Aliens Act on use of force • Ensure records are kept of incidents involving use of force, that incidents are reported within the deadline and that report forms are completed adequately • Amend house rules with information about possible consequences of violations
	• Ensure staff know the different rules on use of force against minors and adults • Ensure medicines are handled in accordance with applicable rules
	• Ensure staff are familiar with the rules of the Act on Adult Responsibility for Children and Young Persons in Placement Facilities on use of force • Ensure children, young people and parents are informed about their rights in relation to use of force when children and young people arrive at the facility • Ensure reporting of all incidents involving use of force
	• Ensure adequate documentation in reports on use of force – including information about who was involved and when the intervention took place • Ensure residents are informed about records of incidents of force being used against them and are given the opportunity to comment on the records • Review incidents involving use of force together with staff for the purpose of learning • Inform residents that they can contact the Danish Immigration Service anonymously about matters of concern • Ensure a general consent to drug tests is given *Case opened on the Ombudsman's own initiative about monitoring of in-house schools of placement facilities and about which rules are applicable to use of force in in-house schools. The case was still pending at the time of going to press*
	Still pending at the time of going to press

4) The table contains selected, abbreviated recommendations. The full recommendations can be found (in Danish only) at www.ombudsmanden.dk, where concluding letters on monitoring visits are published on an ongoing basis. The table includes information about cases taken up on the Ombudsman's own initiative following monitoring visits.

Where did we go in 2018?

When	Where	What	With whom did we speak?		Who also participated?[1]		
			Users[2]	Relatives etc.[3]	DIGNITY	IMR	
24 Apr.	Section for unaccompanied underage foreign nationals at 'Center Sandholm', Birkerød	Asylum centre for unaccompanied underage foreign nationals aged 16 or older with street-oriented behaviour	6	3	✓		
14 to 15 May	'Poseidon', Hurup Thy	Private accommodation facility for, among others, children and young people with an asylum background	3	2			
15 to 16 May	'Mind-move ApS (Busters Verden)', Sabro	Private accommodation facility for, among others, children and young people with an asylum background	2	2		✓	
30 to 31 Oct.	'Sortemosevej', Hjortshøj (**unannounced** visit)	Private accommodation facility for, among others, children and young people with an asylum background	3	3	✓		

	Selected recommendations etc.[4]
	Still pending at the time of going to press
	• Finalise guidelines on use of force so that they conform with legislation • Consider preparing targeted, age-differentiated written information for the children and young people about their rights and duties
	• Consider drawing up more detailed guidelines on use of physical force • Ensure the individual child's/young person's medicine box is labelled with name and civil registration number • Amend guidelines to specify that not only individual staff members but also management may report criminal offences to the police
	Still pending at the time of going to press

Discussions, other activities etc. in relation to both children and adults

Discussions with key authorities

Dialogue with the relevant authorities – both at the local level in connection with monitoring visits and at central level – plays an important part in the Ombudsman's monitoring activities.

The Ombudsman has meetings with key authorities on a regular basis together with the Danish Institute for Human Rights and DIGNITY – Danish Institute Against Torture.

When	Who	Subjects (extracts)
23 May	Department of Prisons and Probation	Healthcare provision in Prison and Probation Service institutions Internal review of placements in security cells Addiction treatment of remand prisoners 15- to 17-year-olds being placed in state and local prisons Written information for 15- to 17-year-old inmates about their rights and duties
6 June	Ministry of Health	Record-keeping of immobilisations with restraint belts during stomach tube feeding Handling of medicines in private accommodation facilities The collaboration between psychiatric wards and social psychiatric residential facilities Passing on of information from hospitals to Prison and Probation Service – for instance in connection with monitoring after suicide attempts So-called satellite pharmacies of Prison and Probation Service
22 June	Ministry for Children and Social Affairs	Deadlines for recording and reporting incidents involving use of force Medical preparedness in connection with solitary confinement of children and young people with mental disorders in secure residential institutions Access to a toilet during solitary confinement in secure residential institutions Absence of action plans for children and young people placed in care outside their home Safety for residents in (social psychiatric) residential facilities

Other activities

- Meetings with foreign (including Nordic) ombudsmen or 'national preventive mechanisms' etc. with discussion and exchange of experience.
- Meeting with a representative from the UN Subcommittee on Prevention of Torture, etc. (SPT).
- Meetings with national monitoring authorities with discussion and exchange of experience.
- Together with DIGNITY – Danish Institute Against Torture and the Danish Institute for Human Rights, the Ombudsman held a meeting with civil society representatives. The objective of the meeting was to inform the participants about our monitoring activities and to obtain information about their experiences and gain inspiration through mutual dialogue.
- As part of the Danish children's ombudsman collaboration, the Ombudsman generally collaborates with the Danish National Council for Children and with Children's Welfare (a Danish organisation offering the Child Helpline, the Children's Chatroom etc.). As part of the collaboration, a dialogue meeting with focus on the well-being of schoolchildren was held with relevant interested parties.

Other results

- In January 2018, the Department of Prisons and Probation sent out new guidelines to Prison and Probation Service institutions about staff monitoring of clients who are deemed at a certain risk of endangering their lives. This step was taken in continuation of the Ombudsman's theme for monitoring visits to institutions for adults in 2014 (prevention of suicides and suicide attempts).
- Following a statement from the Ombudsman, the Department of Prisons and Probation has issued a circular letter about investigation and processing of cases where an inmate complains about having been subjected to abuse etc. by Prison and Probation Service staff. (Circular Letter No. 9088 of 22 February 2018). The Ombudsman's statement concerned an incident where an inmate was pushed several times by a prison guard. (Case No. 2016-52 and news story published on 16 December 2016).
- The Ombudsman raised a number of questions about conditions for 15- to 17-year-old inmates in Prison and Probation Service institutions as part of his theme for monitoring visits to institutions for children in 2017 (young people in secure residential institutions, local prisons and state prisons). (News stories published on 5 September 2017 and 4 July 2018). Subsequently, a number of measures were taken:
  - The Prison and Probation Service has set up a feature in its management information system enabling regional Prison and Probation Service offices to see how many young people under the age of 18 are or were imprisoned on a specific day or during a specific period of time.
  - The Department of Prisons and Probation has drawn up professional standards for inmates under the age of 18. The standards are to support consistent compliance with the special rules applicable for inmates under the age of 18.
  - In 2018, Parliament passed an amendment to the Administration of Justice Act which means that the Minister of Justice lays down special rules on education for remand prisoners of compulsory school age.

Summaries of selected statements – relating to monitoring activities

The Ombudsman regularly publishes statements (in Danish) on selected cases on www.ombudsmanden.dk and on www.retsinformation.dk, the official legal information system of the Danish state.

Summaries are provided on the following pages of the statements published on cases concluded in 2018 which related to monitoring activities.

Ministry of Justice

2018-18. Monitoring visit to Departure Centre Kærshovedgård – foreign nationals with tolerated residence status who were required to reside at the Centre

In October 2017, the Ombudsman carried out a monitoring visit to Departure Centre Kærshovedgård together with DIGNITY – Danish Institute Against Torture and the Danish Institute for Human Rights.

The visit focused on the conditions for foreign nationals with tolerated residence status who were required to reside at Kærshovedgård and in fact resided there. The visit comprised 13 persons who had had tolerated residence status and had been required to reside at the Sandholm asylum centre or at Kærshovedgård for up to 10 years.

The report prepared by the Ombudsman on the visit is to be regarded as a follow-up on the report prepared by the Ombudsman in 2014 on the conditions for the same category of persons, who were at that time placed at the Sandholm asylum centre.

Since 2014, the conditions for this category of persons had changed in a number of respects. A significant change was that they were now required to reside at Kærshovedgård, which is in overall terms considerably more isolated than Sandholm. On the other hand, in the case of a not insignificant proportion of persons with tolerated residence status, the requirement that they reside at Kærshovedgård had been terminated by a court or by the Danish Immigration Service. In the Ombudsman's opinion it could thus be noted that the hopelessness characterising the lives of persons with tolerated residence status had to a certain extent undergone a positive change compared to 2014.

The Ombudsman maintained his view from the 2014 report that the overall conditions for the category of persons on which the visit focused were to be regarded as very stressful and as severely restricting even basic aspects of living. However, the general conditions for these persons did not contravene, for instance, the prohibition of degrading treatment under the UN Convention Against Torture and the European Convention on Human Rights.

2018-39. Unannounced monitoring visits to Departure Centre Sjælsmark – conditions for children

In October 2017, the Ombudsman's Children's Division carried out two unannounced monitoring visits to Departure Centre Sjælsmark. The first visit was carried out together with DIGNITY – Danish Institute Against Torture.

The visits concerned the conditions for children who are housed at the centre with their parents. The children and their families are rejected asylum seekers who do not assist in their deportation and are therefore required to reside at the centre.

The Ombudsman's assessment was that the children housed at the centre were generally to be regarded as living under difficult conditions. He assessed that this was not primarily due to the specific facilities etc. at the centre but to a greater extent to the simple fact that the children were required to reside at the departure centre instead of living in normal society.

Nevertheless, the Ombudsman did not find that the conditions for children at the departure centre could generally be presumed to violate the UN Convention on the Rights of the Child, the UN Convention Against Torture or Article 3 of the European Convention on Human Rights. Further, he stated that the question of the requirement for the families to reside at the departure centre is basically governed by the Aliens Act, i.e. regulated by the legislature. It would therefore be outside the Ombudsman's jurisdiction under the Ombudsman Act to take any further action on the question, among others, of the requirement to reside at the centre.

However, the Ombudsman pointed to some specific aspects of the centre – such as the eating arrangements and the leisure activities available – which could be changed with a view to improving the well-being of the children.

Municipal and regional authorities etc.

2018-26. Boy in care outside his home subjected to illegal monitoring by accommodation facility and municipality

An accommodation facility had, among other things, taken screenshots of the mobile phone of a boy placed in the facility and written down his conversations with his former foster family. The facility had subsequently forwarded the information to the municipality responsible for the placement.

The Ombudsman stated that the boy's communication had been monitored – and that in his opinion it had been monitored illegally because no decision had been made by the municipality's committee for children and young people that the boy's communication was to be monitored.

In addition, the Ombudsman stated that the municipality had had a very significant role in the matter and had in his opinion contributed to a high degree to the boy's communication being monitored by the accommodation facility.

Further, the Ombudsman was of the opinion that even if the authorities obtain consent for the monitoring of the communication of a child or a young person in care outside his or her home, whether from the child or young person or from a person with parental responsibility, it is not possible to dispense with the requirement that the municipality's committee for children and young people must make a decision that the communication is to be monitored before such monitoring can be initiated.

The Ombudsman pointed out that as a result of the fact that no decision had been made, the special legal guarantees in relation to decisions on monitoring the communication of children in care outside their home had not been observed.

In the Ombudsman's opinion the boy's legal rights had been severely infringed.

The Ombudsman decided to notify Parliament's Legal Affairs Committee, the Minister for Children and Social Affairs and the municipal council of the case in pursuance of section 24 of the Ombudsman Act.

Further, the Ombudsman asked the municipality to inform him how it would in future ensure that it observed the rules on initiating monitoring of the communication of children and young people in care outside their home.

Extracts from news – relating to monitoring activities – published on the Ombudsman's website in 2018

The number of subscribers to the Ombudsman's e-mail service where an e-mail is sent out each time a news story is published (in Danish) on the Ombudsman's website was 3,883 as at 31 December 2018. To subscribe to the service, go to www.ombudsmanden.dk/nyhedsbrev/.

The Twitter account @ombudsmanden_ had 1,619 followers.

In the autumn of 2018, the Ombudsman started sending out press releases in addition to news stories. Press releases are more factual and are typically about processes in major cases. Press releases are published on the Ombudsman's website and distributed via Twitter but, unlike news stories, they are not sent to subscribers to the Ombudsman's e-mail service. The following pages only contain news stories, not press releases.

17 January

New initiatives to ensure action plans are made for children placed in care outside their home

Some children who have been placed in care outside their home do not have an action plan despite the fact that this is a statutory requirement and important for the individual child. But now several initiatives are being taken to ensure action plans are made for children placed in care outside their home, the Ministry for Children and Social Affairs writes in a reply to the Ombudsman.

Following monitoring visits to residential institutions for children in care, the Ombudsman carried out an investigation of 26 cases about action plans, 20 of which gave rise to criticism. In May 2017, the Ombudsman therefore asked the Ministry for Children and Social Affairs whether it intended to take any measures as a result of his investigation.

18 January

Problems in relation to use of force in secure residential institution

The number of incidents involving use of physical force was high, the documentation was inadequate in some instances and several incidents had been recorded and reported too late to the relevant authorities.

These were things the Ombudsman's visiting team learnt during a monitoring visit in May 2017 to Egely, a secure residential institution for, among others, young people who are remanded in non-prison custody during investigation of their case. For this reason, the Ombudsman has now sent the institution a number of recommendations.

24 January

Ombudsman to focus on exclusion of inmates from association with other inmates

In 2018 the Ombudsman's Monitoring Department will have special focus on the form of solitary confinement which is called exclusion from association.

6 March

Ombudsman to focus on children with asylum background

This year, staff of the Ombudsman's Children's Division are going to visit a number of children's asylum centres and private accommodation facilities for, among others, children and young people with an asylum background – as the theme chosen for the monitoring visits by the Ombudsman's Children's Division in 2018 is children with an asylum background.

29 May

Ombudsman maintains assessment of conditions for foreign nationals with tolerated residence status

Following two monitoring visits in October 2017 to Departure Centre Kærshovedgård, the Parliamentary Ombudsman maintains his previous assessment of the conditions for foreign nationals with tolerated residence status who are required to reside at a centre. The visits were carried out as a follow-up to similar monitoring visits in 2012 and 2014 to the Sandholm asylum centre, where persons with tolerated residence status were placed at that time.

31 May

Ombudsman opens case about minor inmates' association with adult inmates in Prison and Probation Service institutions

...

In connection with monitoring visits to two closed prisons – Ringe Prison and Nyborg Prison – the Ombudsman has become aware that minor inmates have association with adult inmates. The rules on minor inmates' association with adult inmates set out in the executive order on the handling of 15- to 17-year-old offenders placed in Prison and Probation Service institutions do not apply to these two prisons. For this reason, the Ombudsman has now asked the Department of Prisons and Probation and the Ministry of Justice which guidelines apply to minor inmates' association with adult inmates in the two prisons.

1 June

Concrete measures will be taken to prevent suicides in immigration detention centre

Exposed pipes on the ceilings of the immigration detention centre Ellebæk will soon be hidden. This is the result of the Ombudsman pointing out that in recent years several detainees have attempted to commit suicide using the pipes.

15 June

Resident safety in social psychiatric residential facilities should be improved

After visiting 13 social psychiatric residential facilities in 2017, the Ombudsman concludes that more should be done for resident safety.

4 July

Ombudsman recommends initiatives to improve protection of legal rights of detained young people

When a minor in a secure residential institution is placed in solitary confinement or otherwise subjected to the use of force, the institution should ensure that the incident is reported adequately and within the deadline for reporting such incidents.

This is one of a number of recommendations made by the Parliamentary Ombudsman as part of his investigation of conditions for young people detained in secure residential institutions and local and state prisons. The Ombudsman's recommendations are aimed at improving the protection of the legal rights of these young people.

5 July

15-year-old boy subjected to illegal monitoring by accommodation facility and municipality

A 15-year-old boy who had been placed in care outside his home had his communication with his former foster family monitored for a prolonged period of time. The monitoring consisted, among other things, in staff of the accommodation facility in which the boy was placed taking screenshots of his mobile phone and writing down his conversations without his knowledge. The information was subsequently forwarded to Esbjerg Municipality, the boy's home municipality.

The Ombudsman states that the course of action was illegal and that the boy's legal rights were severely infringed. He also states that Esbjerg Municipality had a very significant share in the responsibility for what happened.

4 October

Placement facilities without an in-house school are not permitted to teach children and young people placed in care outside their home

Children and young people who have been placed in care outside their home are entitled to proper schooling. This means, among other things, that accommodation facilities without an in-house school are not permitted to provide the schooling for these children. So says the Ombudsman in a statement on an investigation which he has just concluded.

20 December

Children at Departure Centre Sjælsmark living under difficult conditions

The conditions for children at Departure Centre Sjælsmark are liable to make their childhood substantially more difficult and to restrict their possibilities of a natural development and self-realisation considerably. This is the Ombudsman's conclusion based on unannounced visits to the centre. He says, among other things, that the children's everyday life appears to be characterised to an appreciable extent by anxiety, loneliness and feelings of unpredictability.

21 December

Death leads to initiatives by Prison and Probation Service

The Ombudsman has investigated a case of a man dying in January 2016 in the Herstedvester prison shortly after having been detained in Vridsløselille, a facility for foreign nationals detained under the Aliens Act. The case has been covered by the media.

Following an internal investigation of the case, the Prison and Probation Service informed the Ombudsman that it had concluded that a number of errors had been made in connection with the man's detention in Vridsløselille. On that basis, the Prison and Probation Service has now implemented a number of measures to prevent the same errors occurring again.

All news stories can be read in full (in Danish) at www.ombudsmanden.dk.

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FOLKETINGETS OMBUDSMAND

Thematic report 2018

Exclusion from association in the institutions of the Danish Prison and Probation Service

Contents

1. What has the theme led to?

Involuntary exclusion from association is a type of solitary confinement which state prisons and local prisons use in relation to inmates. It is particularly used as a preventative measure in order to prevent escape, criminal activity or violent behaviour or to maintain security.

Inmates can also choose to be voluntarily excluded from association with their fellow inmates. This usually happens because the inmate feels that his or her security is threatened by the other inmates.

It is widely recognised that solitary confinement can result in damage to mental health. It is therefore important that solitary confinement is carried out as gently and briefly as possible, and that laws and regulations are observed.

On that basis, exclusion from association with other inmates was chosen as the theme for those monitoring visits which the Danish Parliamentary Ombudsman carried out in the adult sector in collaboration with the Danish Institute for Human Rights and DIGNITY – Danish Institute Against Torture.

The theme was common for all the Ombudsman's visits to state prisons and local prisons. The Ombudsman visited a total of 17 institutions where the theme was relevant. Please see Appendix 1 for a list of the institutions visited, etc.

The Ombudsman's general assessment is that:

- as a general rule, exclusion from association in the institutions of the Danish Prison and Probation Service is carried out in accordance with the underlying Danish rules, but that the documentation should be better.

In 12 of the 17 institutions, this led to the Ombudsman giving one or more recommendations on improvement of documentation and the prison administration following up on the quality thereof.

Furthermore, the Ombudsman has noted the following, among other things:

- There is no general guideline for the staff in the institutions of the Prison and Probation Service on how to handle *voluntary* exclusions.
- The guideline on *involuntary* exclusion does not include all relevant subjects.

In connection with all visits, the Ombudsman's visiting team briefed the prisons on the solitary confinement rules in the UN's new prison rules (the

Nelson Mandela Rules), particularly on the rule on a daily healthcare check of inmates in solitary confinement.

On the basis of the thematic report, the above-mentioned conditions will be discussed with the Department of Prisons and Probation with a view to the Department's consideration and follow-up.

In addition, the Ombudsman will follow up on the recommendations given in connection with the processing of the theme for 2018 on future monitoring visits.

The result of the investigation of the theme for the Ombudsman's monitoring visits is developed further below under Headings 5 and 6.

2. What is exclusion from association, and what are the rules?

According to the Danish Act on Enforcement of Sentences, inmates in state prisons and local prisons shall have access to association with other inmates as far possible. It can be decided under special circumstances, however, that an inmate is excluded from the association or the inmate can wish to be excluded from association voluntarily.

EXCLUSION FROM ASSOCIATION

Exclusion from association can be as follows:

Involuntary exclusion:
- until further notice
- temporary exclusion (max. 5 days)
- exclusion for protective reasons (max. 5 days)

Voluntary exclusion:
- without association
- with access to limited association

As appears above, involuntary exclusion from association can be in the form of exclusion 'until further notice', temporary exclusion or exclusion for reasons of protection.

Involuntary exclusion 'until further notice' can be used by the institutions of the Prison and Probation Service for preventative purposes – particularly to prevent escape, criminal activities, violent behaviour or to maintain security.

Temporary exclusion is a short-term form of exclusion which can be used by the authorities when it is necessary in connection with the processing of questions regarding exclusion from association or with the transfer of the inmate to another state prison or another local prison. Temporary exclusion is for a maximum of 5 days, unless under very special circumstances.

Exclusion for protective reasons can be used by the authorities for up to 5 days if it is necessary in order to protect the inmate from assault.

As mentioned, it can be the inmate's own wish that the sentence is served without or with only limited association with other inmates. Such a voluntary exclusion is often due to the inmate feeling threatened by the fellow inmates.

The rules on involuntary exclusion from association are set down in sections 63 and 64 of the Danish Sentence Enforcement Act, in Executive Order on Exclusion of Inmates from Association (Executive Order No. 429 of 9 April 2015) and in Rules of Guidance on Exclusion of Inmates from Association, including placement in observation cell, etc., in state prisons and local prisons (Rules of Guidance No. 9229 of 13 April 2015). Furthermore, the Department of Prisons and Probation has issued an internal guideline (Instruction Manual) on involuntary exclusion from association and a check list for use in the staff's preparation of reports on exclusion.

With regard to voluntary exclusion from association, it follows from section 33(3) of the Sentence Enforcement Act that a prison sentence is served without or with limited association if it is the inmate's own wish, and conditions allow it. Neither the Executive Order nor the Rules of Guidance stipulate more detailed rules on voluntary exclusion from association.

Generally, the inmate can exercise his or her usual rights during the exclusion. In its mildest form, the exclusion therefore means that the inmate does not associate with other inmates but can otherwise go outside for exercise, either in the prison yard or in the gym, can telephone, receive visits and work in the cell. In state prisons, as a main rule excluded inmates are placed in a special cell in the 'solitary confinement unit' ('isolationsgang' in Danish) while excluded prisoners in a local prison generally stay in their own cell.

Report on exclusion from association
In the case of involuntary exclusion from association the staff shall write a report on the first day of the exclusion.

Among other things, the report shall contain information regarding the grounds for the exclusion and what provision in the Sentence Enforcement Act the decision is based on.

In addition, the report shall contain a reason for the decision, including also statements made by the parties and information on what the staff has told the inmate about the right to complain and about the deadline for complaining. It shall also be recorded whether the inmate's right to be supported by others has been restricted.

According to the Danish Public Administration Act, the inmate does not have a claim on access to files in a case regarding exclusion from association, but in practice the starting point is still that according to the principle of extended openness, the inmate can obtain access to the files in the case, including the reasons for the exclusion, if there are no security reason or other circumstances which contradict it. If access to the reasons for the exclusion cannot be granted, the reasons therefore shall be entered into the report.

Weekly record and re-entry plan
When a decision has been made on involuntary exclusion of an inmate from association, the staff has a duty to continuously assess whether the grounds for the exclusion are still present and to work actively to bring the exclusion to an end.

The institutions of the Prison and Probation Service shall document these conditions in so-called weekly records ('Ugenotater' in Danish) which must also contain a re-entry plan.

The exclusion must be brought to an immediate end when the conditions for it are no longer met. The question of complete or partial cessation shall be considered continuously and at least once a week, and a detailed re-entry plan for how the inmate is going to be included in association again, including how the exclusion can be eased.

The first weekly record must be written at the latest on the seventh day of the exclusion, and the record shall also be sent to the regional office for approval on that day at the latest.

If the exclusion from association lasts more than 7 days, the institution shall subsequently for every 7th exclusion day send a new weekly record with a revised re-entry plan to the regional office.

After 14 days the inmate must be advised on special offers of, for instance, increased contact with staff, check-up by physician/psychiatrist and the option of cell, work or prison yard association with other inmates and on

offers of activities. The purpose of this is to minimise the special strain and risk of mental health damage which is connected with exclusion from association. This guidance must be reflected in the records.

Based on the above-mentioned rules and guidelines, the Ombudsman has composed a check-up form for review of reports and records. The form is annexed as Appendix 2.

There are no rules on reports and follow-up records on voluntary exclusion from association.

3. Background for the choice of theme

Types of solitary confinement and legal guarantees
Several different types of solitary confinement of inmates are used in the institutions of the Prison and Probation Service, including disciplinary cell and exclusion from association. Remand prisoners can also be placed in court-ordered solitary confinement, among other things, for the reasons given in the Administration of Justice Act, while the criminal case is pending.

In practice, the three mentioned types of solitary confinement are carried out in a uniform manner. In principle, the inmate is alone in his or her cell, only interrupted by one hour in the prison yard a day.

The legal protection is, however, different.

An inmate serving a sentence who has been ordered to at least 7 days in a disciplinary cell can demand that the Prison and Probation Service bring the case before the court so that the court can decide whether the decision to place the inmate in a disciplinary cell is lawful. This means that there is an especially easy access to have these cases tried before the courts.

Decisions on court-ordered solitary confinement of remand prisoners have always been taken by a court and shall be continuously reviewed by a court according to the provisions in the Administration of Justice Act.

Conversely, there are no special rules on judicial review in cases regarding exclusion from association. Here, there is solely an administrative complaint procedure – however, with the possibility in the last resort of bringing the issue before the courts by the inmate commencing legal proceedings.

Another difference between involuntary exclusion from association and the two other forms of solitary confinement mentioned above is that exclusion from association has no pre-set end date while court-ordered solitary

confinement and disciplinary cell have a set end date. Detailed rules have certainly been laid down regarding re-assessment of decisions on exclusion from association, cf. the above about weekly records, but the actual decision on exclusion from association does not contain an end date.

If an inmate lets him- or herself be voluntarily excluded from association, there is no access to complaint and nor is there an end date, since the inmate can in principle just decide to return to association with the other inmates.

Exclusions from association are thus subject to a weaker legal protection than the other two forms of solitary confinement, while the lack of an end date must be considered to be more mentally burdensome for the inmate.

Risk of damage to mental health
Scientific studies have shown that solitary confinement has a negative effect on people's mental health. This appears from for instance Danish studies on solitary confinement from 1994 and 1997 (Danish Ministry of Justice (1994): 'Isolationsundersøgelsen. Varetægtsfængsling og psykisk helbred' (*The Solitary Confinement Study. Pre-trial detention and mental health*) and the Danish Ministry of Justice (1997): 'Efterundersøgelsen – en opfølgningsundersøgelse af danske varetægtsarrestanter' (*The Post Review – a follow-up study of Danish remand prisoners*). Both studies are only available in Danish.

Denmark has for many years been criticised both nationally and internationally for its use of solitary confinement in its varying forms.

The use of court-ordered solitary confinement has especially incurred criticism but also the use of exclusion from association and voluntary exclusion have led to recommendations to Denmark from the UN Committee Against Torture (CAT) and the EU Committee for the Prevention of Torture (CPT).

Scale of exclusions from association
In 2015 involuntary exclusion from association 'until further notice' was used in 382 instances, in 2016 in 484 instances, in 2017 in 437 instances and in 2018 in 391 instances. In the period from 2007 till 2015, the level was quite stable at around 700 instances. There has thus been a drop in numbers which seems to be stable.

The Prison and Probation Service's statements for 2017 on the duration of involuntary exclusions show that approximately 80 % of the exclusions had a duration of up to 14 days of which half had a duration of under 7 days. Approximately 10 % lasted more than 14 days and approximately 10 %

lasted more than 28 days. At the time of this thematic report there was no statistical data on the duration of the exclusions in 2018.

With regard to voluntary exclusions, the number seems to go up. In 2015 voluntary exclusion was used in 664 instances, in 2016 in 663 instances, in 2017 in 794 instances and in 2018 in 774 instances.

The Prison and Probation Service's statements for 2017 on the duration of voluntary exclusions show that approximately 27 % had a duration of under 7 days, approximately 28 % lasted between 7 and 14 days, approximately 15 % lasted between 14 and 28 days, while approximately 30 % lasted more than 28 days.

The Prison and Probation Service's analysis in 2016
In the 2nd half of 2016 the Department of Prisons and Probation carried out an analysis (a so-called performance audit) of the use of involuntary exclusion from association which came to the overall conclusion that the case processing in this field was not satisfactory.

The analysis resulted in the drafting in the spring of 2017 of, among other things, a check list to be used by staff in connection with documentation for the involuntary exclusion from association.

The Department has not issued a guideline on the use of voluntary exclusion, nor have any analyses been made thereof.

Reports to the Ombudsman on prolonged exclusions
The Ombudsman has an agreement with the Department of Prisons and Probation to receive reports on the very prolonged involuntary exclusions, meaning exclusions lasting more than 3 months.

For the period from 2015 till 2017, the Ombudsman has received 3 reports of this type.

Furthermore, in connection with monitoring visits over the years the Ombudsman has seen instances of very prolonged voluntary exclusions and seen that temporary exclusions in certain instances have exceeded the time limit of 5 days.

Choice of theme
Based on the conditions described, the Ombudsman found, in collaboration with the Institute for Human Rights and DIGNITY – Danish Institute Against Torture, that there were grounds for carrying out a more detailed examination of the conditions for excluded inmates in connection with the monitoring visits in the adult sector in 2018.

4. How did the Ombudsman proceed?

4.1. How was the investigation planned?

The theme has been investigated through 17 visits to institutions under the Prison and Probation Service: 4 closed state prisons, 4 open state prisons and 9 local prisons.

In his selection of the 17 institutions, the Ombudsman has taken into account, among other things, which of the institutions had statistically the highest number of exclusions. However, some institutions were selected because the Ombudsman had not visited these institutions for some considerable time.

The monitoring visits were carried out as part of the Ombudsman's general monitoring activities according to section 18 of the Ombudsman Act and as part of the Ombudsman's task concerning the prevention of people deprived of their liberty being exposed to for instance inhuman or degrading treatment, cf. the Optional Protocol to the UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT).

The Ombudsman's task concerning the prevention of degrading treatment, etc. in relation to the Protocol is carried out in collaboration with the Danish Institute for Human Rights and DIGNITY – Danish Institute Against Torture. DIGNITY – Danish Institute Against Torture contributes to the collaboration with medical expertise. The Danish Institute for Human Rights contributes with special human rights expertise. This means, among other things, that staff from the two institutes with this expertise participate in the planning, execution and follow-up regarding monitoring visits.

4.2. What did the Ombudsman investigate?

Under the year's theme, the following was examined, among other things:

- Does the documentation in the exclusion cases show that the exclusion is based on correct grounds?
- Does the documentation show that rules are otherwise observed?
- How has the development in the use of exclusions been over the last 3 years?
- What information does management receive on the use of exclusions, and how does management use this information, including for the purpose of prevention?
- Does management systematically ensure that staff are trained in correct prevention, follow-up and writing reports?
- How does the institution prevent and handle voluntary exclusions?
- What observations do staff carry out in relation to the inmate during the exclusion, and how are any harmful effects of the exclusion prevented?

- Has the prison had exclusions which have been more prolonged than the basis for the exclusion has given cause for?
- Are there medical health checks of excluded inmates?

4.3. How were conditions investigated?

Prior to each visit, the Ombudsman has asked the individual institution for reports and other relevant material, for instance weekly records and re-entry plans, for 3 concrete involuntary exclusions. One of these exclusions should be the one which had been of the longest duration within the last 12 months and the 2 others should be the two most recent that had lasted more than 5 days.

Furthermore, the institutions were asked for a series of statistical data concerning exclusions from association and for accounts of preventive measures, implementation and follow-up concerning exclusions.

In Appendix 3 there is an example of an opening letter which shows the information which the institutions have been asked to send prior to the Ombudsman's visit.

During the monitoring visits, the Ombudsman's visiting teams went into more detail regarding the written information about the subject of the theme through interviews with management, staff, including priest and physician, and with inmates.

Management and staff are interviewed on, among other things, compliance with the Prison and Probation Service's check list on the subject and on how exclusion from association is handled in practice with regard to preventive measures and implementation, including whether daily healthcare checks are carried out. Furthermore, the Ombudsman's visiting team has discussed the result of the review of the 3 reports with management and has interviewed management about its use of statistical data and quality control of the writing of reports.

The inmates have been interviewed on the course of exclusions in practice, as experience shows that this can be perceived in different ways by staff and inmates. A question guide for use in interviews with inmates has been formulated. The question guide can be found as Appendix 4.

In the course of the year's thematic visits, the Ombudsman's visiting teams have spoken with a total of 200 inmates of whom 15 inmates were or had been involuntarily excluded from association 'until further notice' at the institution in question, 15 inmates who were or had been voluntarily excluded from association at the institution in question, and 5 inmates who were temporarily excluded on the day of the visit.

5. What did the Ombudsman find out?

5.1. Review of reports

In the course of 2018 the Ombudsman visited 17 institutions where the use of exclusion was examined in more detail, cf. Heading 4.1 above.

Before the visit, 11 of the institutions had sent in 3 reports on involuntary exclusion from association 'until further notice' for the Ombudsman's review. The other 6 institutions did not have any reports on prolonged exclusions of the nature which the Ombudsman had asked for in his opening letter. However, one of the institutions instead sent 2 reports on involuntary temporary exclusion which were also reviewed by the Ombudsman.

In the case of voluntary exclusions there is, cf. Heading 2 above, no duty to write a report or to complete weekly records. Consequently, the Ombudsman has only reviewed statistics about the number and duration of voluntary exclusions in the institutions visited for 2015, 2016 and 2017, but not reviewed other written material.

Apart from the 2 above-mentioned reports, also temporary exclusions and exclusions for reasons of protection have only been examined through a review of the statistics for number and duration for 2015, 2016 and 2017.

5.1.1. Were the grounds for implementing exclusion correct?

The Ombudsman's review of the reports on exclusion from association and of other material, such as for instance interrogation reports or underlying reports on finds of illegal objects, showed that all exclusions complied with the requirements of the law in as far as the grounds for implementing the exclusions were concerned.

On that basis, the Ombudsman has not given any recommendations with regard to the grounds for implementing exclusions.

5.1.2. Were the grounds for continued exclusion correct?

Weekly records

The Ombudsman's review of the reasons contained in the weekly records showed that the grounds for continuing to exclude an inmate from association were present, except in those cases where capacity problems were the cause, cf. below.

The Ombudsman's visiting teams noted, though, that the description in the weekly records of what it would take to end the exclusion in some cases just said that the inmate should cease the behaviour which had caused the exclusion, for instance 'cease threatening behaviour'. However, there was no

detailed description of the way in which the inmate continued to exhibit threatening behaviour or of which behavioural changes were needed.

During the visits, the brief descriptions were expanded on through verbal explanations from management and in certain cases documented by underlying reports. It was a question of a lack of written documentation in the weekly records and not that the grounds for continued exclusion of the inmate were not present, cf. below under Heading 5.1.4 on documentation.

On that basis, the Ombudsman's visiting teams did not give any recommendations in relation to the question of grounds for the continued exclusion of the inmates.

Capacity problems regarding exclusions 'until further notice'
In open state prisons the decision on involuntary exclusion 'until further notice' led to transfer of the inmate to a closed state prison or a local prison in several cases. In these cases the Ombudsman found that the conditions for excluding the inmate from association 'until further notice' had been met when the exclusion was implemented but not at a later time when the inmate continued to be excluded from association. It appeared from the weekly records in these cases that the inmate continued to be excluded from association solely because he or she were to be transferred from an open state prison to a closed state prison or to a local prison and the open state prison was waiting for a place for the inmate. The continued exclusion was therefore due to capacity problems in closed settings (closed state prisons and local prisons).

In the Ombudsman's opinion, the decision to transfer to a closed setting observed the rules in these cases but the lack of capacity in the closed settings does not, according to the underlying rules, constitute sufficient grounds for excluding an inmate from association. The exclusion from association must be ended immediately when the conditions therefore are no longer met.

Management in the open state prisons agreed with the Ombudsman's visiting teams that a lack of capacity in closed state prisons and local prisons does not constitute sufficient grounds for the continued exclusion of an inmate. It is noted in this context that all the concrete exclusions had ended at the time of the Ombudsman's visit, and that the inmates had been transferred.

However, the lack of capacity in the closed state prisons and local prisons is not the responsibility of the individual open state prison, and the Ombudsman will discuss with the Department of Prisons and Probation the lack of capacity and the resulting problem with compliance with the rules on exclusion from association.

Capacity problems on exclusion for protective reasons
When an inmate is excluded for protective reasons, the solution is often to move that individual to another institution.

As there are presently very few available places in the institutions under the Prison and Probation Service, the same problem arises as mentioned above under capacity problems on exclusion 'until further notice', namely that the possibility of transferring the inmate is lacking.

On reviewing the statistical lists of exclusions from association for protective reasons, the Ombudsman's visiting teams found that the existing maximum limit of 5 days had been exceeded in several instances.

In most of the cases, management stated that these cases involved problems with transfer of the inmate to an institution where the inmate could be secure in association with other inmates.

The Ombudsman will also take this issue up with the Department at a meeting.

Recording problems on temporary exclusions
In a number of instances, the Ombudsman's review of statistical lists showed that temporary exclusions from association had lasted longer than the 5 days which is the maximum limit.

The explanation in these cases was usually that there had been mistakes made in the recording of the exclusion. The temporary exclusion should have been recorded in the client file management system as ended because the inmate had transferred to exclusion 'until further notice' or had been placed in a disciplinary cell.

However, a few of the delays in the 5 day limit were due to the fact that the temporary exclusion had taken place over a weekend which had delayed the processing of the temporary exclusion case. In these few instances, the delays were 2 days at most.

As recorded non-compliance with deadlines is a general problem for the 12 institutions, the Ombudsman will take up the issue at a meeting with the Department of Prisons and Probation.

5.1.3. Did the documentation live up to requirements?

Reports
There were documentation problems to a greater or lesser degree in practically all reports on exclusion from association.

All the 12 institutions which prior to the Ombudsman's visit had sent in reports on exclusion from association were therefore recommended to increase their focus in precise and adequate documentation in reports and weekly records.

The typical errors in the documentation were the following:

- The grounds for the exclusion appeared solely with reference to an underlying report and not by a description of the matter in the actual report on exclusion from association.
- Reference to the provisions for the grounds for the exclusion was missing or incorrect.
- The description was insufficient or completely absent.
- The report gave incorrect indication of whether the inmate was entitled to access to files in the case pursuant to the principle of extended openness.
- The inmate's mental state was not described in the report.
- The report lacked information on the inmate's remarks in connection with the decision to exclude the inmate from association.
- Information on the inmate's medication was indicated differently in the report and in the weekly note or was not given at all.
- It did not appear from the report whether guidance on complaint had been provided.
- It did not appear from the report whether a deadline for complaint had been given.

In addition to this, there were other documentation deficiencies to a varying degree but of less significant importance. These were for instance writing errors or information that was filled in wrongly.

Weekly records
The Ombudsman's investigation showed that also the weekly records were in many cases not completed fully in accordance with the provisions.

The typical errors were the following:

- No information on whether or not the inmate had spoken with a priest, physician, psychologist or others.

- No information on whether or not – and if so how – the inmate was motivated to speak with a priest, physician, psychologist or others.

- No information on the mental health state of the inmate.

- No information (at exclusions lasting more than 14 days) on whether the inmate was offered free television.

- No information (at exclusions lasting more than 14 days) on whether the inmate was offered special access to individual tuition and work or other activity.

The Ombudsman also noted in a few cases that the weekly records had not been written on the week day and that notification to the Department of Prisons and Probation had not been carried out after 14 days' exclusion.

5.1.4. Was management's follow-up adequate?

Quality assurance of reports and weekly records
As outlined above, there were generally errors in the documentation concerning exclusions in all the institutions whose reports and weekly records were reviewed.

In 9 of the institutions it was the assessment of the Ombudsman's visiting teams that management's quality assurance of the reports and the weekly records was inadequate or in certain cases not established at all.

The Ombudsman's visiting teams therefore recommended to these institutions that management – in the way which management deemed relevant – undertook a continuous quality assurance in connection with exclusion from association and ensured appropriate training/instruction of staff regarding the requirements for reports and weekly records on exclusion from association.

Management's use of statistics
When visiting state prisons and larger local prisons, the Ombudsman's visiting teams found that managements knew about and at planned intervals followed up on developments in the number of exclusions from association and made analyses of the background for the development. In certain places, managements of comparable institutions also had discussions on differences between these institutions and the reasons therefore.

One visit showed that there was not the necessary insight into the development of the use of voluntary as well as involuntary exclusions. On that background, the Ombudsman's visiting team recommended that the institution's management follow up on this development, among other things by analysing the causes for the development and to a relevant extent comparing themselves with other institutions.

The smaller local prisons did not have the same systematic approach to follow-up of developments. The Ombudsman's visiting teams assessed that this was not necessary anyway due to the relatively low number of exclusions which these institutions have and they therefore did not give any recommendations on the subject to the smaller local prisons.

5.2. Are state prisons and local prisons focused on avoiding the necessity of exclusion?
It was the assessment of the Ombudsman's visiting teams during the visits to 17 institutions that management and staff are in general focused on avoiding that involuntary or voluntary exclusion from association become necessary.

On that background, no recommendations on increased focus on avoiding exclusion were given during the visits.

The Ombudsman's visiting teams also found, though, that there was some difference between the quality and intensity of the institutions' efforts to build a good relationship with the inmates which can be of importance to the task of avoiding that exclusion becomes necessary. However, the differences had to do with the size and function of the institutions. In the small local prisons with 20-25 inmates and a correspondingly small number of prison officers a good relationship with the inmates is thus easier to establish than in a large, closed state prison with many inmates and many prison officers.

The assessment of the Ombudsman's visiting teams is based on information from management as well as staff and inmates.

Management and staff generally stated during the visits that there is an extensive focus on the effort to build a good relationship with the inmates as the principle foundation for creating an environment which makes it safe to be

in the state prison or local prison. Staff pointed out particularly that familiarity with the individual inmates was important – and was prioritised – so that as a member of staff you could discuss problems concerning for instance family or other inmates with the individual inmate.

However, in several institutions management and staff pointed out that the institution was in a difficult situation due to a shortage of uniformed staff. They also pointed out that the relationship between staff and inmates was important to the dynamic security but that relations were under pressure due to the staff shortage. In addition, the use of disciplinary cells and voluntary exclusion from association was on the increase which tied up extra staff resources for writing reports and monitoring the inmates.

The majority of those inmates in involuntary exclusion with whom the Ombudsman's visiting teams spoke recognised that they had been involved in violations of the rules and that staff had just followed the rules.

The majority of those inmates in voluntary exclusion with whom the Ombudsman's visiting teams spoke had no objections to the way in which staff had tried to solve the problems before the exclusion. Several inmates praised certain members of staff for having made particular efforts to solve the problems.

Generally, the inmates in the institutions visited stated that the relationship with staff was good.

However, the majority of the inmates also remarked that staff had become very busy.

5.3. Do state prisons and local prisons have focus on carrying out the exclusion in a way which prevents any mental health damage?

The Ombudsman's visiting teams assessed that management and staff in the institutions visited generally had relevant knowledge of how exclusion can lead to mental health damage and of how such damage can be prevented. This was true both of involuntary and voluntary exclusions.

As appears below, however, the regime for inmates who were excluded from association, and thereby also the prevention of the risk of mental health damage, varied greatly in the different institution types. The visiting teams could also see that there were differences in the preventive measures in similar institutions, just as the individual staff member's experience with and insight into behavioural changes in inmates in solitary confinement played a role in the preventive measures.

Furthermore, it was found that the institutions did not have procedures in place which ensured that there was notification of for instance physician or priest regarding inmates who were excluded from association and that the possibility of introducing such procedures was not supported by the client management system of the Prison and Probation Service. And the client management system did not allow staff the possibility of retrieving information about the overall number of days that a given inmate had been in solitary confinement in his or her cell.

At a meeting with the Department of Prisons and Probation, the Ombudsman will discuss the possibilities for general improvement of the prevention of any mental health damage in relation to both involuntary and voluntary exclusion through extension of the guidance on involuntary exclusion and through drafting guidance for involuntary exclusion, cf. see below for more details.

As both management and staff in the institutions visited had relevant knowledge of the fact that exclusion can result in mental health damage and how such damage can be prevented, and as none of the excluded inmates whom the visiting teams spoke with stated that they had been mentally damaged – though several indicated that it had been hard mentally – no concrete recommendations on improving the prevention of possible mental health damage were given.

Information from management and staff on the effort
It was the general opinion of management and staff that the inmates are well looked after in connection with exclusion from association. If there were problems with inmates who were excluded from association, this was discussed by staff and management. It was, however, general for all the institutions visited that the measures which staff implemented in relation to the voluntarily excluded were not documented.

Staff stated that they were very attentive of behavioural changes in excluded inmates. Among special focus areas were mentioned, among other things, a lack of appetite, avoidance of eye contact, no wish to communicate, changes in daily routine, changes in behaviour and level of aggression, and choosing not to go for exercise in the prison yard or to use the gym. If such changes occurred, staff would have a talk with the inmate to motivate him or her for activities. However, none of the managements or staff of the institutions visited could remember any more recent instances of exclusion from association where the exclusion had been terminated due to changes in the inmate’s behaviour.

The inmates' information about the measures
The Ombudsman's visiting teams spoke with a total of 15 inmates who had been excluded from association. The inmates' experience of the exclusion differed somewhat from the assessment of management and staff.

Of the 15 inmates in total, about half stated that they had felt it to be mentally hard to be excluded. They had not been automatically seen by healthcare staff who only came by on request, and they stated that they had felt forgotten and that time went by very slowly. They passed the time in watching television and for some inmates with reading.

The other half of the inmates had a less negative experience of time as excluded from association. These inmates typically had had some association, some in the form of working with other inmates or joint exercise in the prison yard with another inmate in solitary confinement. Some of the inmates had had tuition in their cell or had visits from the priest.

The 15 inmates who had been or were voluntarily excluded and with whom the Ombudsman's visiting teams spoke were mainly positive in relation to the implementation of their exclusion. There were thus generally positive assessments of staff's focus on alleviating the consequences of not having association with others. However, the inmates also stated that some days could feel very difficult and long.

Varying regimes in the institutions
The Ombudsman's visiting teams found during the visits that exclusion from association is practised with great variation because of the institutions' dissimilarity.

Seen generally, there is a more restrictive regime in the closed state prisons – with the Copenhagen Police Headquarters Prison as the most restrictive. The inmates who are excluded from association in the closed state prisons have the most restrictions in freedom and possibilities of having meaningful social contact in the course of the day.

In the open state prisons there are a higher degree of freedom for inmates excluded from association, and in the small local prisons – following an individual assessment of the inmate – it is only the association with other inmates that is restricted. Thus, in small local prisons the inmate – in addition to outdoor exercise in the prison yard and in the gym – will also be let out of his or her cell when other inmates are locked inside their cells.

The least restrictive regime was practised in Herstedvester Prison where the inmates generally were not actually excluded from association with other inmates but rather restricted in their freedom of movement. They could

therefore leave their rooms themselves and to a certain extent be in the common rooms but were forbidden to enter the rooms of the other inmates. Only in instances where this restriction of their freedom of movement was not respected, was a more restrictive regime implemented.

Measures to counteract mental health damage
In the Exclusion from Association Order and its appurtenant Rules of Guidance there are laid down rules on the special rights and options to which an inmate is entitled after 14 days of involuntary exclusion.

The excluded inmate shall be offered increased contact with staff, examination by a physician, including a psychiatrist, etc., association with one or more inmates in the cell or during outside exercise in the prison yard, the possibility of working together with others, leisure time activities with one or more of the other inmates or with staff, and be offered regular and prolonged talks with for instance a priest, physician or psychologist.

The excluded inmate must also be provided with free television and have special access to individual tuition and work, including other approved activity which can help reduce the special strain and risk of adverse effects on mental health which is connected with exclusion from association.

Nothing similar applies for inmates who are voluntarily excluded – not even when the inmate has no association with others.

Voluntary exclusions with no possibility of association can be of very long duration. At a visit to one institution, the Ombudsman's visiting team noted that in 2017 and 2018 there had been 6 voluntary exclusions without possibility of association which had lasted over 100 days. The longest duration was for 579 days.

The Ombudsman's visiting teams found furthermore that none of the institutions visited had routine procedures for notifying healthcare staff about exclusions. Neither were priest, teachers, substance abuse therapists or social worker notified according to routine procedures.

In addition, none of the institutions had local in-house guidelines on prevention of possible mental health damage as a result of exclusion (or other forms of solitary confinement), and therefore the follow-up in relation to the excluded inmates relied very much on the staff's knowledge of and insight into the inmate's mental state.

Overall, it is established *that* that there are significant differences in the institutions' regime for the execution of exclusions, *that* there is a difference in the insight of individual members of staff into what changes in an inmate's

behaviour that must be seen as warning signs of mental health damage, and *that* there are differences in how the institutions react to inmates showing signs of behavioural changes during the exclusion.

Furthermore, there are measures not taken today, including systematic notification of healthcare staff, priest, teachers, substance abuse therapists and social worker. Such an automatic notification could mean that the knowledge these professionals have regarding less robust inmates could be included in the way the exclusion is implemented.

The Ombudsman therefore recommend in general that the Department of Prisons and Probation consider laying down instructions for the institutions' prevention of any mental health damage. The existing guideline on involuntary exclusion could with advantage be expanded with instructions on this subject.

Correspondingly, there should be guidelines laid down on prevention of any mental health damage in connection with voluntary exclusion.

The recommendations on expansion of the guideline for involuntary exclusions and establishment of guidelines for voluntary exclusions will be discussed with the Department of Prisons and Probation.

The overall time an inmate spends in solitary confinement
The duration of solitary confinement is of significant importance to the incidence of mental health damage. The longer a person is in solitary confinement, the higher the risk of mental health damage. This has been documented in numerous scientific studies.

The Ombudsman has therefore examined more closely whether the duration of solitary confinement is included in the Prison and Probation Service's decisions on and implementation of exclusion from association.

Based on the records of the use of disciplinary cell, observation cell and security cell together with exclusions from association which the Ombudsman received prior to the visits, it could be established that certain inmates could spend a very long time in involuntary exclusion. For one particular inmate it was 115 days out of a calendar year.

During the visits, managements stated that it is not possible in the client management system of the Prison and Probation Service to retrieve information about the total number of days any given inmate has been in solitary confinement. A search for the total number of days in solitary confinement for any given inmate would therefore require a manual review of the individual inmate's files in the client management system. Whether there

was awareness of the increased risk of mental health damage which too many periods of solitary confinement can cause, and whether the decision to exclude an inmate took this into account, were therefore dependent on the individual interrogation officer's memory or information from other members of staff. In by far the majority of the institutions, this question was not checked before a decision to exclude an inmate was made.

In the Ombudsman's opinion, it is important – when making a decision to place an inmate in solitary confinement – that there is knowledge of how long the inmate has already been in solitary confinement in the previous period so that the increased risk of mental health damage liable to be caused by long-time solitary confinement can be taken into account. In a modern IT system, such information should be available via simple commands.

It is therefore the Ombudsman's view that in a future up-date of its client management system or when acquiring a new system, the Department of Prisons and Probation should ensure that this facility is available and utilised.

The Ombudsman will discuss this issue at a meeting with the Department.

6. The Nelson Mandela Rules

The so-called Nelson Mandela Rules are the UN's new international prison standards. The rules reflect the development in the view of prison conditions over the last decades and provide in a number of areas a more extensive protection of inmates than previous prison standards.

The UN's Nelson Mandela Rules were adopted at the UN General Assembly on 17 December 2015. The rules are an up-dated version of the old UN Standard Minimum Rules for the Treatment of Prisoners from 1955. The rules are not binding for the Member States as they are a so-called recommendation.

The new rules establish a number of minimum standards for the treatment of inmates in state prisons and local prisons. Of special relevance in connection with exclusion from association, the following rules on pre-trial detention in solitary confinement and placement in solitary confinement cell can be mentioned:

- A definition of solitary confinement as confinement for 22 hours or more a day without meaningful human contact.
- A general prohibition on solitary confinement for more than 15 consecutive days, including that the period of solitary confinement shall be as short as possible and only be used in exceptional cases.

- A requirement that solitary confinement shall be subject to independent review.
- A requirement that healthcare personnel shall visit inmates in solitary confinement daily and that inmates with mental or physical disabilities shall not be placed in solitary confinement.
- A requirement that healthcare personnel shall continuously inspect and report unacceptable and degrading conditions in prisons and if necessary recommend that the solitary confinement be terminated.

The rules can found in No. 43-46 in the Nelson Mandela Rules, cf. Appendix 5.

In connection with all visits, the Ombudsman's visiting teams informed the institutions about the rules on solitary confinement contained in the UN's Nelson Mandela Rules, including particularly the requirement for a daily visit from healthcare personnel to inmates in solitary confinement.

However, the Ombudsman's visiting teams learned in the course of the visits that many local prisons do not employ nurses and that medical service with a physician is restricted to a few hours a week.

In a meeting with the Department of Prisons and Probation the Ombudsman will discuss the impact of the rules on persons in solitary confinement in Danish state prisons and local prisons.

7. Summary of the Ombudsman's recommendations and considerations regarding the theme

- In 12 out of 17 institutions the Ombudsman's visiting teams recommended an increased focus on precise and adequate documentation in reports and weekly records.

- In 9 out of 17 institutions the visiting teams recommended that the institutions' management ensure continuous quality control of the written documentation and training/instruction of staff in requirements for reports and weekly records on exclusion from association.

The Ombudsman will discuss the following issues and general recommendations with the Department of Prisons and Probation:

- That the Department ensures that maintaining an involuntary exclusion from association only takes place when the rules for this are observed so that for instance inmates to be transferred from an open to a closed state

prison or local prison are not kept excluded from association due to a lack of places in the closed setting.

- That the guideline on involuntary exclusion is expanded with a section on prevention and early intervention regarding any mental health damage and on follow-up regarding exclusion from association.
- That a guideline on voluntary exclusion from association be drafted with directions on preventive measures and early intervention regarding any mental health damage and on follow-up regarding exclusion from association.
- That in connection with a future up-date of its client management system, or when acquiring a new system, the Department ensures that when a decision is to be made on whether or not an inmate should be placed in solitary confinement, the system automatically produces information on the individual inmate's overall time in all forms of solitary confinement during his or her imprisonment so that this information can be included when the decision is made.

Furthermore, the Ombudsman will discuss with the Department of Prisons and Probation the significance of the UN's Nelson Mandela Rules in relation to persons in solitary confinement in Danish state prisons and local prisons.

Louise Vadheim Guldberg
Direktør

Director General

Annex

Appendix 1

Where	With whom did we speak		Who also participated?		Recommendations regarding the theme
	Inmates	Relatives and guardians	DIGNITY	IMR	
17 visits	Talks with **200**	**1** talk	**17** visits	**7** visits	Visits concluded with recommendations regarding the theme: **12** Visits concluded without comments regarding the theme: **5**
'Herstedvester Fængsel', Albertslund (closed special prison)	37	1	√	√	• that focus on precise and adequate documentation in reports and weekly records about exclusions from association is increased • that the prison management ensure – in the way the management consider relevant – regular quality control of the written documentation in connection with exclusion from association • that the prison management ensure in a systematic way that staff are trained in correct report writing

Where	With whom did we speak		Who also participated?		Recommendations regarding the theme
	Inmates	Relatives and guardians	DIGNITY	IMR	
'Sdr. Omme Fængsel' (open prison)	4	0	√	√	• that focus on precise and adequate documentation in reports and weekly records about exclusion from association is increased, among other things in relation to information about, respectively, activities offered and carried out with inmates, what medicine inmates have been given in which periods, whether guidance on complaint has been given, and information about the grounds for the exclusion • that prison management ensure – in the way the management consider relevant – regular quality control of the written documentation in connection with exclusion from association as well as training of/instructions to staff as regards requirements for reports and weekly records about exclusion from association (cf. check lists, etc., which the Department of Prisons and Probation has issued)

Where	With whom did we speak		Who also participated?		Recommendations regarding the theme
	Inmates	Relatives and guardians	DIGNITY	IMR	
'Kragskovhede Fængsel', Jerup (open prison)	10	0	√		• that the prison's focus on precise and adequate documentation in reports and weekly records about exclusions from association is increased. This applies, among other things, in relation to the grounds (it is not sufficient to merely refer to an underlying report), whether they have been 'ticked' correctly as to extended openness, which activities have been, respectively, offered and carried out with inmates, and that records are made about inmates' mental state during the exclusion • that prison management ensure – in the way the management consider relevant – regular quality control of the written documentation in connection with exclusion from association and training of/instructions to staff as to the requirements for reports and weekly records about exclusion from association (cf. check list and 'Instruction Manual', etc., which the Department of Prisons and Probation has issued) • that the institution's management/the regional office follow up on the development in the use of both voluntary as well as involuntary exclusions and carry out analyses of the reasons for the developments
'Nyborg Fængsel' (closed prison with section for remand prisoners)	32	0	√	√	• that the in-house set of rules, if maintained, is kept updated so that it is consistent with applicable law • that focus on precise and adequate documentation in reports on exclusion from association is increased, among other things, respectively, in relation to information about activities offered and carried out with inmates

Where	With whom did we speak		Who also participated?		Recommendations regarding the theme
	Inmates	Relatives and guardians	DIGNITY	IMR	
'Nr. Snede Fængsel' (open prison with closed sections)	26	0	√		• that motivation of inmates to get out of voluntary exclusion from association is documented • that prison management analyse the cause of the increase in the number of disciplinary cell decisions • that the in-house guidelines, including the provisions of exclusion from association, are updated if they are maintained • that management focus on the overall development in number of exclusions, duration of the exclusions and possibility of association • that focus on precise and adequate documentation in reports on exclusion from association is increased, among other things in relation to the grounds for the exclusion as well as recording of information as to whether it was an exclusion from association and how long it lasted

Where	With whom did we speak		Who also participated?		Recommendations regarding the theme
	Inmates	Relatives and guardians	DIGNITY	IMR	
'Enner Mark Fængsel', Horsens (closed prison with section for remand prisoners)	10	0	√		• that focus on precise and adequate documentation in reports and weekly records about exclusions from association is increased, among other things in relation to the grounds stated, including the kind of exclusion implemented, whether a regard for extended openness has been taken into account, which activities have been, respectively, offered and carried out with the inmate, and information about the inmate's mental state during the exclusion • that prison management ensure – in the way the management consider relevant – regular quality control of the written documentation in connection with exclusion from association and training of/instructions to staff as to the requirements for reports and weekly records about exclusion from association (cf. check list and 'Instruction Manual', etc., which the Department of Prisons and Probation has issued)

Where	With whom did we speak		Who also participated?		Recommendations regarding the theme
	Inmates	Relatives and guardians	DIGNITY	IMR	
'Søbysøgård Fængsel', Årslev (open prison with closed section)	14	0	√	√	• that the in-house set of rules is updated in regard to time limits for complaints so that it is accordance with the applicable rules • that focus on precise and adequate documentation in reports and weekly records about exclusions from association is increased, among other things in relation to the grounds stated, whether regard to extended openness has been taken into account, which activities have been, respectively, offered and carried out with the inmate, and information about the inmate's mental state during the exclusion • that prison management ensure – in the way the management consider relevant – regular quality control of the written documentation in connection with exclusion from association and training of/instructions to staff as to the requirements for reports and weekly records about exclusion from association (cf. check list and 'Instruction Manual', etc., which the Department of Prisons and Probation has issued)

Where	With whom did we speak		Who also participated?		Recommendations regarding the theme
	Inmates	Relatives and guardians	DIGNITY	IMR	
'Københavns Fængsler, Politigårdens Fængsel' (the monitoring visit concerned a specific remand prisoner excluded from association for a long time)	0 (the inmate did not wish to speak with the visiting team)	0	√	√	• that prison management try to extend the inmate's time out of the cell with visits to the training facilities when deemed justifiable on safety grounds

'Køge Arrest' (local prison)	9	0	√		• that focus on precise and adequate documentation in reports and weekly records about exclusion from association is increased, among other things in relation to information about which activities have been, respectively, offered and carried out with inmates, what medicine inmates have been given during which periods of time and inmates' mental state during the exclusion • that prison management ensure – in the way the management consider relevant – regular quality control of the written documentation in connection with exclusion from association and training of/instructions to staff as regards requirements for reports and weekly records about exclusion from association (cf. check lists, etc., which the Department of Prisons and Probation has issued) • that the local guidelines with the heading 'Local guidelines for involuntary exclusion from association' are rephrased, if maintained • that the prison management contact the regional office in regard to a change in the wording on the time limit for the applicable instructions on appropriate sanctions so that they meet applicable rules • that it is ensured that all solitary confinement cell reports contain documentation that an assessment was made upon initiation and that a continuous assessment has been made of the need for restraint used on the inmate placed in the cell • that the accuracy in connection with record of solitary confinement cell reports in regard to staff's monitoring and observations is increased

Where	With whom did we speak		Who also participated?		Recommendations regarding the theme
	Inmates	Relatives and guardians	DIGNITY	IMR	
'Kalundborg Arrest' (local prison)	9	0	√	√	*No theme recommendations*
'Holstebro Arrest' (local prison)	8	0	√		*No theme recommendations*
'Københavns Fængsler', Vestre Fængsel (Copen-hagen Prison, Western Prison)	5	0	√	√	*No theme recommendations*
'Ringkøbing Arrest' (local prison)	7	0	√		*No theme recommendations*
'Esbjerg Arrest' (local prison)	5	0	√		• that focus on precise and adequate documentation in reports on exclusion from association is increased, among other things in relation to information as to grounds, particulars of the case and correct completion of the section regarding extended openness • that the prison management ensure – in the way the management consider relevant – a better quality control of the written documentation in connection with exclusion from association in addition to training of/instructions to staff as regards requirements for reports and weekly records about exclusion from association (cf. check lists, etc., which the Department of Prisons and Probation has issued) • that it is ensured that staff checks take place as often as laid down in the rules and that the time of the checks is stated in the solitary confinement cell reports

Where	With whom did we speak		Who also participated?		Recommendations regarding the theme
	Inmates	Relatives and guardians	DIGNITY	IMR	
'Helsingør Arrest' (local prison)	9	0	√		• that notification to healthcare staff is introduced in connection with new exclusions in the local prison • that the prison management make sure that reports on temporary exclusions sufficiently document the grounds for the temporary exclusion, including among other things on which rules of law the decision was reached and whether complaint guidance was given
'Odense Arrest' (local prison)	10	0	√		• that prison management ensure – in the way the management consider relevant – regular quality control of the written documentation in connection with exclusion from association • that focus on precise and adequate documentation in reports and weekly records about exclusions from association is increased, among other things regarding reference to correct provisions about exclusion from association, information about grounds, whether they have been 'ticked' correctly as to extended openness, what kind of medicine has been given to inmates and during which period of time
'Aalborg Arrest' (local prison)	5	0	√		• that prison management increase their focus that documentation in reports regarding involuntary exclusion is correct, precise and adequate • that prison management – in the way the management consider relevant – make sure that a regular quality control of the written documentation in connection with exclusion from association, among other things, is carried out

Appendix 2

Check list form for review of reports and records

_____ _____

Institution Name of inmate

Control of the decision record

	Yes	No
Is a date stated in the record as to when notice of the decision was given	☐	☐
Is the time when notice of the decision was given stated in the record	☐	☐
Has information about access to assistance and the right to give one's opinion been given	☐	☐
Has the right to receive assistance been restricted	☐	☐
Have hearings been conducted	☐	☐
• If yes, did the inmate approve his statement	☐	☐
Has information about complaint options been given	☐	☐
Has information about time limit for lodging a complaint been given	☐	☐
Has information been given as to which rules of law the decision was based on	☐	☐
Is it stated which information/incidents form the basis of the exclusion	☐	☐
Are the grounds for the decision stated	☐	☐
• If yes, can the conclusion be reached that conditions for necessity, proportionality and indication are observed	☐	☐
Has the inmate been informed about the grounds	☐	☐

Control of weekly records

Have weekly records been worked out for each commenced week	☐	☐
• If yes, has it been considered whether the exclusion can partly be terminated	☐	☐
Has a re-entry plan on how the inmate could be included in the association again been worked out	☐	☐

Exclusions exceeding 14 days and up to 3 months

Has the exclusion been reported to the Department of Prisons and Probation	☐	☐
Has the inmate received guidance on/been offered regular talks of long duration with:		
priest	☐	☐
doctor	☐	☐
or psychologist	☐	☐
Offered free TV at his or her disposal	☐	☐
Offered special access to individual tuition and work	☐	☐
other activity	☐	☐

Have relaxations in the form of cell association been considered	☐	☐
association during exercise in the	☐	☐
prison yard	☐	☐
working association	☐	☐
or leisure time activities with staff	☐	☐

	Yes	No
Have staff been aware whether the excluded inmate has a special need for:		
increased contact with staff	☐	☐
medical attention by doctor/psychiatrist	☐	☐
Is the exclusion expected to last longer than 3 months	☐	☐
• If yes, has a recommendation been sent to the Department of Prisons and Probation after 10 weeks	☐	☐

Appendix 3

Opening letter

Monitoring visit to [redacted] Prison (thematic visit)
As agreed by telephone with institution manager [redacted], the visit to [redacted] Prison is scheduled for **Wednesday [redacted] 2018.**
The visit starts at 9:00 am.

There are no specific conditions at [redacted] Prison leading to the Ombudsman's wish to visit the prison. The monitoring visit is conducted as part of the Ombudsman's general monitoring activities and as part of the Ombudsman's OPCAT activities, cf. below reasons for and purpose of the visit.

As the theme for 2018, the Ombudsman has chosen to look into conditions for inmates who are excluded from association in state prisons and local prisons. The theme comprises both involuntary exclusions, including temporary exclusions according to section 63(2) of the Sentence Enforcement Act, as well as voluntary exclusions.

Therefore, the visit will primarily focus on conditions for these inmates. Consequently, some of the information which the Ombudsman has requested is related to the conditions for these inmates.

In addition to this, the visit can also include questions on the use of physical force, interventions and restrictions, relations, healthcare conditions as well as work, education and leisure time activities.

The visiting team consists of Director General Louise Vadheim Guldberg, Deputy Head of Department Erik Dorph Sørensen and Legal Case Officer Rikke Malkov-Hansen from the Ombudsman institution, Chief Medical Officer Jens Modvig from DIGNITY – Danish Institute Against Torture and Senior Researcher Peter Vedel Kessing from the Danish Institute for Human Rights.

I must ask you to make sure that a permission is available upon commencement of the visit that legal case officer Rikke Malkov-Hansen is permitted to bring along a laptop during the visit.

Information in advance
For my preparation of the visit, I ask that I receive various types of information on **Tuesday XXXX 2018** at the latest:

1. House rule(s)

2. A list with the number of times physical force has been used within the last three years, divided into types of force and number of inmates
3. A list with the number of involuntary and voluntary exclusions from association within the last three years with information about the duration, and in regard to the involuntary exclusions also with information about the grounds for the exclusion
4. A list with the number of placements in disciplinary cell within the last three years with information about duration of the placement
5. A list with the number of placements in observation cell and solitary confinement cell (if there are such cells) within the last three years with information about the grounds for and duration of the placement
6. A list with the number of occurrences of abuse, violence and threats about violence within the last three years (both among inmates, against inmates as well as against staff)
7. Guidelines for the processing of cases about violence and abuse, etc. (anti-violence policy)
8. Written in-house guidelines, if any, regarding involuntary exclusion from association
9. Written in-house guidelines, if any, regarding voluntary exclusion from association
10. Reports and other relevant material, for example weekly records and re-entry plan, for three involuntary exclusions. One of the exclusions must be one which has lasted the longest during the last year, and the other two exclusions must be the latest exclusions lasting longer than 5 days.
11. Information about number of exclusions, where the decisions have been appealed, with statement of the number of cases where the decision has been overruled, or cases where the Department of Prisons and Probation has stated that relevant rules have not been observed.
12. If possible, a list with 5 inmates who are still in prison and who have been involuntarily excluded from association the longest time (overall) over the past year
13. If possible, a list with 5 inmates who are still in prison and who have been voluntarily excluded from association the longest time (overall) over the past year
14. A list with inmates, who according to the point below about ’Notice and information to inmates about the visit’ have been informed about the visit. The list must contain information about name, age, gender, time of imprisonment and any special needs, including mental illness.
15. An updated occupancy rate of the prison with information about the inmates’ name, age, gender, time of imprisonment and any special needs, including mental illness.

Furthermore, I ask the prison to send me a report on the following:

a. Which significant, problematic incidents the prison has experienced in 2017.
b. A report with the reason for the development in the number of exclusions, if a development has occurred.
c. A report on which information the prison management receive about the use of exclusions and how the prison management use the information, including with a view to preventive measures.
d. A report on how the prison handles voluntary exclusions, including how the prison prevents voluntary exclusions, which observations the prison makes regarding the inmate at this stage and how the prison prevents any damaging effects from the exclusion.

When the material is sent, I ask that it is numbered in accordance with the points above. Any confidential information can be sent to me via ordinary post but you are also welcome to send it to me via secure e-mail to post@ombudsmanden.dk.

Programme for the visit
The visit is primarily carried out through talks with the prison management, staff and inmates who would like to talk with the visiting team.

Moreover, the visiting team would also like to talk with the prison's doctor and priest.

Talks with inmates will take place both with inmates who in advance have notified that they are interested, and those who know that on the visiting day, the visiting team will ask a number of selected inmates whether they would like to talk with the team.

Talks with staff can, if possible, be carried out as group talks if the staff wish to do it this way.

The visiting team primarily wishes to talk with inmates who are or have been excluded from association (both involuntary as well as voluntary exclusion), and, in addition to this, also inmates who are currently placed in solitary confinement. The visiting team would also like to talk with representatives, if any, for the inmates, including possible spokespersons and staff representatives.

I therefore ask the prison to make sure that this will be possible.

I ask that the talks are carried out at times that fit into the prison's programme for the day, and that it is possible in terms of time to have talks with inmates

who did not notify their interest in a talk in advance. At present, it is not possible to say exactly how long the individual talks are going to take but in principle it is a question of fairly brief talks of approximately 15 minutes' duration. The visiting team has the option of splitting into two groups, making it possible to carry out two talks at a time.

The visit also includes a presentation tour of the prison inmates' physical environment.

The visiting team wants the visit to open and close with meetings with the prison's management. The visiting team expects that the opening meeting is going to last approx. 2 hours and that the closing meeting is going to last approx. 1 hour. Prior to the closing meeting, the visiting team has a pre-meeting of approx. 45 minutes' duration.

At present, it is not possible to say when the visit is going to end on the day. Among other things, this depends on the number of persons asking for a talk.

On this background, I ask the prison to send me a suggestion for a programme for the visit, including the talks mentioned. The prison is welcome to contact me for further clarification of the planning of the visit. I ask that I receive the programme and a list of inmates who wish to talk with us on **Thursday [redacted] 2018 at the latest.**

If, prior to the visit but after the prison has worked out a suggestion for a visiting programme, more requests for a talk with the visiting team should arise among inmates, I ask you to change the programme so that these talks can also be carried out on the day of the visit, and that the prison upon commencement of the visit hands out a copy of the possibly changed programme to me.

Notice and information to inmates about the visit
I ask that the prison put up the enclosed notice in Danish and English about the visit only in the prison's solitary confinement and exclusion sections and in any way which the prison finds most suitable will pass on information to the inmates about the visit.

I also enclose the guide 'Visit from the Parliamentary Ombudsman'.
Please hand out the guide to inmates who are or have been subject to exclusion within the last 3 months and who are still in prison. Please also hand out the folder to inmates who within the last month have been subject to another kind of isolation for more than 5 days, as well as to others who wish to have a talk. These inmates must be informed verbally about the Ombudsman's visit and the possibility of having a talk with the Ombudsman's visiting team.

Background and purpose of the visit
The Parliamentary Ombudsman is regularly carrying out monitoring visits, among other things to institutions where people are or can be deprived of their liberty. Partly, the monitoring visits are carried out as part of the Ombudsman's general monitoring activities pursuant to section 18 of the Ombudsman Act, cf. Consolidation Act No. 349 of 22 March 2013, and partly in accordance with the Optional Protocol to the UN Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, cf. Executive Order No. 38 of 27 October 2009. The Ombudsman's work of preventing degrading treatment, etc. in accordance with the Protocol is carried out in collaboration with the Danish Institute for Human Rights and DIGNITY – Danish Institute Against Torture.

Pursuant to section 21 of the Ombudsman Act, the Ombudsman shall in connection with his activities, including his monitoring visits, assess whether persons or authorities falling within his jurisdiction act in contravention of existing legislation or otherwise commit errors or derelictions in the discharge of their duties. In connection with the Ombudsman's monitoring activity, section 18(ii) of the Act also applies. Pursuant to this provision, the Ombudsman can, in addition to assessments pursuant to section 21, assess matters concerning the organisation and operation of an institution or authority and matters concerning the treatment of and activities for users of the institution or authority on the basis of universal human and humanitarian considerations.

If the prison has any questions in connection with the monitoring visit, you are welcome to contact the undersigned or XXXX on telephone number + 45 33 13 25 12.

Appendix 4

Question Guides

Question guide for voluntarily excluded inmates

Fact sheet

- How long have you been excluded
    - How did it take place (specific incident or from the beginning)?
        - Could it have been avoided?
- How is your everyday life/describe a day.
    - Who do you see?
        - Are you in contact with relatives/is it possible for you to make telephone calls?
        - Are you in contact with healthcare staff/priest/social worker?
        - Do you have the possibility of undertaking activities/occupation/education?
            - What do you get out of it? Do you look forward to it/is it meaningful?

Information

- What kind of information did you receive from staff/how was the information passed on to you?
- Were you informed of the consequences of exclusion?
    - How did the information affect you?
        - Did you feel that you had a choice?
- Have you received information as to which offers/initiatives staff can make available to you during the exclusion?
- Did anyone talk with you about the possibilities of being released from exclusion?
    - Have you considered it yourself?
    - Is staff doing any follow-up?
    - What are staff doing to support you?
    - Has a re-entry plan been drawn up for you?

Well-being/health/impacts

- Have you been admitted to a hospital?
    - If yes, for what reason?
        - Did it occur during the exclusion or is it something which you have been admitted to hospital for previously?
- Have you otherwise been in contact with healthcare staff?
    - If yes, on what occasion?

        - Is it because of something that occurred during the exclusion, or is it because of something that you have been treated for in the past?
- We have heard from other institutions that isolated inmates can suffer from anxiety and/or melancholy. Do you also experience that?
- WHO-5 (Please tick the field at each of the 5 statements which comes closest how the excluded inmate has felt the last two weeks. Please note that a higher figure represents better well-being).

During the last 2 weeks …	**5 All the time**	**4 Most of the time**	**3 A little more than half of the time**	**2 A little less than half of the time**	**1 A little of the time**	**0 At no time**
.. I have been happy and in a good mood						
.. I have felt calm and relaxed						
.. I have felt active and energetic						
.. I have woken up fresh and re-energized						
.. my everyday life has been filled with things that are interesting to me						

Possibility of relaxing restrictions/cessation

- Do you have the possibility of associating with other inmates who are excluded?
    - If yes, do you make use of this possibility?
- Do you have increased access to:
        - work?
        - leave?
        - possibility of making a telephone call?
        - books/TV?
- Now that you are excluded, is there anything you wish would be different?

Question guide for involuntarily excluded inmates

Fact sheet

- How long have you been excluded?
    - What was the course of events up to your exclusion?
        - Could it have been avoided?
- How is your everyday life/describe a day.
    - Who do you see?
    - Are you in contact with healthcare staff/priest/social worker?
    - Are you in contact with relatives/are you allowed to make telephone calls?
    - Do you have any possibility of activities/occupation/education?
        - What do you get out of it? Do you look forward to it/is it meaningful?

Information

- What kind of information did you receive from staff/how was the information passed on to you?
- Were you informed about the possibility of being released from exclusion?
    - Is this discussed with you on a continuous basis?
    - Has a re-entry plan been drawn up for you?

Well-being/health/impacts

- Have you been admitted to hospital?
    - If yes, for what reason?
        - Did it occur during the exclusion or is it something which you have been admitted to hospital for previously?
- Have you otherwise been in contact with healthcare staff?
    - If yes, on what occasion?
        - Was it because of something that occurred during the exclusion, or was it because of something that you have been treated for in the past?
- We have heard from other institutions that isolated inmates can suffer from anxiety and/or melancholy. Do you also experience that?
- WHO-5 (Please tick the field at each of the 5 statements which comes closest how the excluded inmate has felt the last two weeks. Please note that a higher figure represents better well-being).

During the last 2 weeks …	**5 All the time**	**4 Most of the time**	**3 A little more than half of the time**	**2 A little less than half of the time**	**1 A little of the time**	**0 At no time**
.. I have been happy and in a good mood						
.. I have felt calm and relaxed						
.. I have felt active and energetic						
.. I have woken up fresh and re-energized						
.. my everyday life has been filled with things that are interesting to me						

Possibility of relaxing restrictions/cessation

- Did you receive any information as to which offers/initiatives staff can make available to you during the exclusion?
    - Do you have increased access to
        - work?
        - leave?
        - possibility of making telephone calls?
        - books/TV?
- Now that you are placed in solitary confinement, is there anything you wish would be different?

Appendix 5

United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules)

Rule 43

1. In no circumstances may restrictions or disciplinary sanctions amount to torture or other cruel, inhuman or degrading treatment or punishment. The following practices, in particular, shall be prohibited:

(a) Indefinite solitary confinement;
(b) Prolonged solitary confinement;
(c) Placement of a prisoner in a dark or constantly lit cell;
(d) Corporal punishment or the reduction of a prisoner's diet or drinking water
(e) Collective punishment.

2. Instruments of restraint shall never be applied as a sanction for disciplinary offences.
3. Disciplinary sanctions or restrictive measures shall not include the prohibition of family contact. The means of family contact may only be restricted for a limited time period and as strictly required for the maintenance of security and order.

Rule 44

For the purpose of these rules, solitary confinement shall refer to the confinement of prisoners for 22 hours or more a day without meaningful human contact. Prolonged solitary confinement shall refer to solitary confinement for a time period in excess of 15 consecutive days.

Rule 45

1. Solitary confinement shall be used only in exceptional cases as a last resort, for as short a time as possible and subject to independent review, and only pursuant to the authorization by a competent authority. It shall not be imposed by virtue of a prisoner's sentence.
2. The imposition of solitary confinement should be prohibited in the case of prisoners with mental or physical disabilities when their conditions would be exacerbated by such measures. The prohibition of the use of solitary confinement and similar measures in cases involving women and children, as referred to in other United Nations standards and norms in crime prevention and criminal justice, continues to apply.

Rule 46

1. Health-care personnel shall not have any role in the imposition of disciplinary sanctions or other restrictive measures. They shall, however, pay particular attention to the health of prisoners held under any form of involuntary separation, including by visiting such prisoners on a daily

basis and providing prompt medical assistance and treatment at the request of such prisoners or prison staff.

2. Health-care personnel shall report to the prison director, without delay, any adverse effect of disciplinary sanctions or other restrictive measures on the physical or mental health of a prisoner subjected to such sanctions or measures and shall advise the director if they consider it necessary to terminate or alter them for physical or mental health reasons.
3. Health-care personnel shall have the authority to review and recommend changes to the involuntary separation of a prisoner in order to ensure that such separation does not exacerbate the medical condition or mental or physical disability of the prisoner.

FOLKETINGETS OMBUDSMAND

Thematic report 2018

Use of force and other interventions in asylum centres and in privately-run accommodation facilities for, i.a., children and young people with asylum background

Contents

1. Introduction

The use of force and other interventions in asylum centres for children and in private accommodation facilities for, among others, children and young people with asylum background was the theme for the monitoring visits to the children's sector in 2017 which the Ombudsman carried out in cooperation with the Danish Institute for Human Rights and DIGNITY – Danish Institute Against Torture.

CHILDREN AND YOUNG PEOPLE WITH ASYLUM BACKGROUND

The theme concerned children and young people with an asylum background.

It encompassed children and young people

- who were either asylum seekers or rejected asylum seekers or
- who had been granted a residence permit.

The children and the young people were mostly unaccompanied underage foreign nationals.

The children and the young people were 10-18 years of age.

The children and young people who were asylum seekers or rejected asylum seekers were generally placed in asylum centres for children pursuant to the Danish Aliens Act while the children and young people who had been granted a residence permit were typically placed in private accommodation facilities pursuant to the Danish Act on Social Services.

1.1. What has the theme led to?

1.1.1. As mentioned above, the theme concerned the use of force and other interventions.

The visits showed that the majority of the centres and facilities visited use force to a limited extent in relation to the children and the young people, and that there is a general awareness of the need to ensure that the best interest of the child or the young person is given primary consideration when force is used.

However, the visits also showed that in several centres and facilities there is an inadequate knowledge of the legislation on the use of force.

On that basis the Ombudsman recommends in general that asylum centres for children and accommodation facilities ensure that the staff are familiar with the legislation on the use of force, and that guidelines on the use of force are in compliance with the legislation. The Ombudsman also recommends in general that the asylum centres and accommodation facilities ensure that children, young people, parents and personal representatives are informed of their rights in relation to the use of force when the children and the young people arrive at the institution.

Please see under Heading 2 for more details about the investigation's findings regarding the use of physical force.

The Ombudsman will discuss the follow-up on these general recommendations with the central authorities in the sector. In addition, the Ombudsman will follow up on the recommendations during his monitoring visits.

1.1.2. During the monitoring visits the Ombudsman also examined whether the visited institutions ensure that the municipality is informed when the institutions are concerned about the wellbeing of a child or a young person.

The visits showed that there is a general awareness of the duty to notify the municipality of children and young people who may have need of special support.

However, the visits also showed some problems in relation to the practice followed in regard to notification.

One problem is whether a close cooperation with the municipality may involve a risk that notifications about specific children and young people may not be sent to the municipality, even though it is required according to the rules on the duty of notification. The problem has presented itself in connection with several monitoring visits to accommodation facilities. The Ombudsman will discuss the question with the Ministry for Children and Social Affairs.

In one asylum centre for children the problem was that the centre did not send notifications to the municipality if the young person, about whom the centre believed it had a duty to send a notification, disappeared or stayed away from the centre before the notification was sent. The Ombudsman has decided to investigate this practice on his own initiative.

Please see under Heading 3 for more details about the findings of the investigation into the practice for notification.

1.1.3. In connection with the visits the Ombudsman also noticed other problematic issues in the asylum centres for children and private accommodation facilities.

The visits uncovered, among other things, that there are problems with the management of medicine at the accommodation facilities. The Ombudsman therefore makes the general recommendation that the accommodation facilities ensure that the management of medicine takes place in accordance with the existing rules. Please see more details on this under Sub-heading 4.2.

The Ombudsman has discussed the follow-up on this recommendation with the Ministry of Health and will also discuss it with the Ministry for Children and Social Affairs. In addition the Ombudsman will follow up on the recommendation during his monitoring visits.

Furthermore, monitoring visits to asylum centres for children have caused the Ombudsman to raise own-initiative questions with the Danish Immigration Service about the supervision of education in in-house schools in asylum centres for children and about which rules regulate the use of force in such schools. Please see more details on this subject under Sub-headings 5.2 and 5.3.

In addition, the Ombudsman is considering whether there are grounds for an own-initiative investigation of a private accommodation operator's use of a private company for, among other things, the use of force at an asylum centre for children according to the rules of the Danish Aliens Act. Please see more details on the case under Sub-heading 2.5.

Some issues the Ombudsman has chosen to discuss at meetings with the central authorities.

Among other things, several of the visited institutions offered addiction treatment to the children and the young people. On that background, the Ombudsman has discussed the right to addiction treatment and the treatment's content and effect with the Ministry of Health and he will also discuss the matter with the Ministry for Children and Social Affairs and the Danish Immigration Service. Please see more details about addiction treatment under Sub-heading 4.3.

During a monitoring visit to an asylum centre for children the Ombudsman noticed that information about the children and the young people and their health could be recorded in various places. The Ombudsman will therefore discuss record-keeping and the exchange of health information between the

asylum centres with the Danish Immigration Service. Please see more on this under Sub-heading 4.4.

1.1.4. The Ombudsman has sent this report to all competent authorities in the sector: The Ministry for Children and Social Affairs, the National Board of Social Services, the local social supervision authorities, the Ministry of Immigration and Integration, the Danish Immigration Service, the Ministry of Health and the Danish Patient Safety Authority.

The purpose is to make the report known to the authorities so that it may be included in their deliberations regarding the matter.

The report has also been sent to the private accommodation facilities and asylum centres for children which the Ombudsman visited as part of the theme.

In addition, the Ombudsman has notified the following about the report: The Danish Parliament's Legal Affairs Committee, the Danish Parliament's Domestic and Social Affairs' Committee, the Danish Parliament's Health and Senior Citizens' Committee, the Danish Parliament's Immigration and Integration Committee, the Danish Parliament's Supervisory Board in accordance with Section 71 of the Constitutional Act, Local Government Denmark and the Danish Refugee Council.

Please see more details about the Ombudsman's thematic work under Sub-heading 6.2 in the Appendix.

1.2. Background for the choice of theme

1.2.1. The Ombudsman's monitoring activities are especially aimed at the most vulnerable members of society. Characteristic of these vulnerable citizens is, among other things, that they have very few resources and that their rights can easily come under pressure. This can also apply to children and young people with an asylum background.

1.2.2. With this theme, the Ombudsman wanted to gain an increased insight into the conditions for children and young people with an asylum background and to examine these conditions in more detail.

In relation to the asylum centres for children it was important for the Ombudsman to get an impression of how the centres use the new rules in the Danish Aliens Act on the use of physical force in relation to unaccompanied underage foreign nationals which came into force on 1 September 2017.

During the visits to the accommodation facilities it was important for the Ombudsman to gain an insight into the way in which the facilities use the rules on the use of physical force in the Danish Act on Adult Responsibility.

Both in the asylum centres for children and in the accommodation facilities the Ombudsman wanted to examine whether the centres and facilities make sure that they notify the municipality when they are concerned about the well-being of a child or young person.

1.2.3. The theme started from some of the general focus areas which the Ombudsman uses during his monitoring visits.

The Ombudsman has for example a general focus on the use of force and other interventions and restrictions. The Ombudsman also has a general focus on relations, including the institutions' information to the children, the young people, parents and personal representatives about their rights.

In addition, the Ombudsman has, among other things, a general focus on education and health care matters, including the management of medication.

1.3. How did the Ombudsman proceed?

1.3.1. The Ombudsman carried out nine visits with the aim of clarifying and examining the theme of the use of force and other interventions in children's asylum centres and private accommodation facilities for children and young people with asylum background, among others.

The visits involved five private accommodation facilities for, among others, children and young people with an asylum background. Furthermore, the visits involved four asylum centres for unaccompanied underage foreign nationals, including two centres for, among others, minors with street-oriented behaviour and a special placement facility for unaccompanied underage foreign nationals with a behaviour for which an ordinary asylum centre for minors does not have the capacity. In this report this special placement facility is included in the category 'asylum centres for children'.

One visit was unannounced while the other visits were announced in advance.

1.3.2. The theme focused on the following:

- use of physical force
- practice regarding notification of municipalities about children and young people.

1.3.3. The Ombudsman asked for the following information, among other things, from the institutions visited:

- guidelines for the use of force and information on how the child or young person and his/her representative or holder of parental responsibility are informed of their rights in relation to the use of force and other interventions in the right to self-determination, including any channel of complaint
- a list of the number of times when force has been used over the last three years with copies of the institution's five most recent reports of the use of physical force in relation to children and young people
- information on those children and young people who attend school, including the type of educational programme
- medication management instructions
- a list of notifications to the municipality over the last three years and what measures resulted from the notification
- a brief account of, among other things, how the institution ensures that the well-being of the child or young person is prioritised in measures concerning children and young people, including when force is used.

1.3.4. In the week leading up to the announced monitoring visits the Ombudsman sent a personal letter to each individual child and each individual young person and informed them of the visit and the possibility of having an interview with the visiting team. With the letter the Ombudsman enclosed a folder which described what the children and young people could for instance talk to the visiting team about. The folder, which is available in Danish and English, is annexed to this report.

In the case of the unannounced visit the staff and the monitoring team verbally informed the young people about the visit and the possibility of having an interview with the visiting team.

The purpose of this approach is to get to talk to as many children and young people as possible because they are a substantial and important source of information for the Ombudsman.

During the monitoring visits the visiting teams had talks with 44 out of a total of 74 children and young people. In addition, the visiting teams talked with relatives, personal representatives and guardians and staff, including teachers and management.

The talks concerned in particular use of physical force and the practice for notifying the municipality about the children and young people but also for instance health care matters, education and the interpersonal relationships between the children and young people.

1.3.5. The monitoring visits were carried out as part of the Ombudsman's general monitoring activities pursuant to the Parliamentary Ombudsman Act and as part of the Ombudsman's task of preventing that persons who are or who can be deprived of their liberty are exposed to for instance inhuman or degrading treatment, cf. the Optional Protocol to the UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.

The Ombudsman's work to prevent degrading treatment, etc. pursuant to the Protocol is carried out in cooperation with the Danish Institute for Human Rights and with DIGNITY – Danish Institute against Torture.

DIGNITY and the Institute for Human Rights contribute to the cooperation with special medical and human rights expertise, meaning among other things that staff with expertise in these two fields participate on behalf of the two institutes in the planning and execution of and follow-up on monitoring visits.

The Ombudsman has a special responsibility to protect children's rights according to, among others, the UN Convention on the Rights of the Child. The Ombudsman's special advisor on children's issues participates in monitoring visits in the children's sector.

1.4. What did the Ombudsman find?

Based on the monitoring visits he carried out, the Ombudsman noted the following, among other things:

- There is a general awareness of ensuring that the well-being of the child or the young person is given primary consideration, also in connection with the use of force.
- The majority of the institutions visited use force to a limited extent.
- In several institutions, there is inadequate knowledge of the legislation on the use of force.
- A number of institutions have not updated, completed or drafted guidelines on the use of force.
- In many institutions children, young people, parents and personal representatives are not given sufficient information about their rights in relation to the use of force when the children and the young people arrive at the institution.
- There is a general awareness of the duty to notify the municipality about children and young people who may be in need of special support.
- There is no general basis for assuming that notification does not take place when there is cause to do so.
- There are problems with management of medication in private accommodation facilities.

- Many institutions face challenges with children and young people who have lost hope of a future in Denmark as a result of being refused a residence permit, who have substance abuse problems or a street-oriented behaviour, or who disappear.

2. Use of physical force

2.1. The rules

The best interest of the child shall be a primary consideration in all actions concerning children, says the UN Convention on the Rights of the Child.

The staff in accommodation facilities and asylum centres for children can use physical force towards a child or a young person. This follows from the Danish Act on Adult Responsibility and the Danish Aliens Act.

USE OF PHYSICAL FORCE

Who and what
Staff can *take hold of or lead* a child or a young person to another room.

When
Physical force can be used when the child or the young person exhibits a behaviour which *endangers the child or the young person or others at the location*.

Documentation and hearing
The institution shall *record and report* the use of physical force.

The child or the young person shall be informed of the report and have *the opportunity to make a statement*.

Information
The child or the young person and parents or a personal representative shall be *informed of their rights in relation to the use of force and other interventions in the right to self-determination*, including channels of complaint, when they arrive at the institution.

2.2. Extent and documentation

The visits showed that the majority of the visited institutions use force to a limited extent in relation to the children and the young people.

This conclusion is based partly on information from the institutions on the number of times when force was used over the last three years, partly on the

reports which the Ombudsman received in reply to his request that the institutions send him the five most recent reports on the use of physical force.

The overall result of the nine visits to accommodation facilities and asylum centres for children was that the Ombudsman received 18 reports on the use of physical force (a total of six reports from the five accommodation facilities and a total of 12 reports from the four asylum centres for children). It should be pointed out that with regard to the asylum centres for children the Ombudsman concentrated on reports concerning incidents which took place after the Aliens Act's new rules on the use of force came into force on 1 September 2017.

The Ombudsman reviewed the accommodation facilities' reports by use of the checklist form in Appendix 6.4, while the checklist form in Appendix 6.5 was used in reviewing the reports from the asylum centres for children. The review showed that there is a general awareness of ensuring that the best interests of the child and the young person is given primary consideration when force is used.

To a relevant extent, the review formed the basis for discussions between the visiting teams and the places visited.

On the basis thereof, the Ombudsman gave recommendations on for instance ensuring that the use of force is recorded and reported in time, that reporting forms on the use of force are adequately completed, that all uses of force are recorded and that the young people are informed about the recording of the use of force and are given the opportunity to accompany the report with their own account.

2.3. Knowledge of the rules and the drafting of guidelines

2.3.1. Children and young people living in asylum centres for children and in accommodation facilities shall be treated with dignity, considerately and in accordance with their rights. In order to ensure this, it is for instance vital that the staff know the rules on the use of force and other interventions in the right to self-determination.

In connection with the monitoring visits the Ombudsman gave a number of recommendations that accommodation facilities and asylum centres ensure that the staff know the rules on the use of force and other interventions in the right to self-determination.

The Ombudsman also gave this recommendation to an accommodation facility which had not had any incidents involving the use of force, as it is

important that the staff know the rules if a situation arises where the use of force is necessary.

On that basis the Ombudsman generally recommends that asylum centres for children and accommodation facilities ensure that the staff know the legislation on the use of force.

2.3.2. As a general rule, force should not be used in relation to children and young people in accommodation facilities and asylum centres for children.

However, the use of force may be warranted in order to ensure the right to due care for children and young people. Thus, force may only be used as a last resort in the attempt to help a child or a young person after all pedagogical options have been exhausted.

This also means that situations may arise where regard for the child's or the young person's right to due care makes it necessary for the staff to use force. It is therefore important that the staff is familiar with the rules and that the staff in the situation actually use the necessary force out of a regard for the child's or young person's right to due care.

In one asylum centre talks with the staff could leave the impression that the staff withdrew in concrete situations instead of considering to employ those possibilities for using force which the Aliens Act provides. The Ombudsman's visiting team therefore advised the centre that it is not appropriate to withdraw in all cases.

Staff in another asylum centre did not take action towards the young people for security reasons but called the police. A young person in the centre asked when the staff would gain control of the hash smoking in the centre. The centre did not use the new rules in the Aliens Act on searching persons or rooms but, as aforementioned, called the police.

The Ombudsman recommended that it was ensured that the staff were aware of their authority according to the Aliens Act to use force and other interventions in the right to self-determination.

2.3.3. Local guidelines on the use of force that explain the legislation in an easily understood way – for instance in the shape of headlines – may help ensure that the staff are sufficiently familiar with the rules.

It is of course vital that such guidelines comply with the legislation, including new legislation with impact on how the staff is allowed to use force in relation to the children and the young people.

New rules in the Aliens Act on the use of force in relation to unaccompanied underage foreign nationals placed in an asylum centre came into force on 1 September 2017.

The Ombudsman recommended to all asylum centres for children that they update or complete guidelines on the use of force so that these comply with the new rules.

Regarding accommodation facilities, the Ombudsman recommended to one accommodation facility that it complete its guidelines on the use of force and ensure that the guidelines comply with the legislation, while another accommodation facility was recommended to consider drafting more detailed guidelines. A third accommodation facility was recommended to consider drafting guidelines.

On that basis the Ombudsman generally recommends that the asylum centres for children and the accommodation facilities ensure that guidelines on the use of force comply with the legislation.

2.4. Information about rights

It is important that children, young people, parents and representatives are informed of their rights.

When a child or a young person is placed at an asylum centre for children or an accommodation facility, the manager must inform the child or the young person and the custodial parent or the child's or young person's representative of their rights in connection with the use of force and other interventions in the right to self-determination, including any channels of complaint. This follows from the Act on Adult Responsibility and the Aliens Act.

As it is crucial that the child or the young person and parents and representatives know their rights in relation to the use of force, the Ombudsman has, as part of the monitoring visits, obtained data on how asylum centres and accommodation facilities provide this information.

The visits uncovered that the information that was given was not sufficient. Consequently, the Ombudsman made a number of recommendations.

On that basis the Ombudsman makes the general recommendation that asylum centres for children and accommodation facilities ensure that children, young people, parents and personal representatives are informed of their rights in relation to the use of force when the children and young people arrive at the centre or facility.

2.5. Use of private operator, including for the use of force

In connection with monitoring visits to, among others, two asylum centres for children the Ombudsman learned that a private accommodation operator uses staff from a private company, and that staff from the company can, among other things, use force in relation to the residents. Accordingly, a guard from the company had used force in relation to a resident at the children's centre.

The Ombudsman is considering whether there are grounds for starting an own-initiative investigation of the accommodation operator's use of the private company.

To help him in his deliberations the Ombudsman has asked the Danish Immigration Service to state what tasks the company carries out for the operator and the basis for the operator using the company, including for the execution of force according to the rules of the Aliens Act.

In addition, the Ombudsman has asked the Immigration Service to state whether the cooperation agreement between the operator and the company contains what is required of the company. The case is still pending.

3. Notification of municipalities

3.1. The rules

The best interest of the child shall be a primary consideration in all actions concerning children, says the UN Convention on the Rights of the Child.

Staff in accommodation facilities and asylum centres for children shall observe the duty pursuant to the Danish Social Services Act of notifying the municipality when they are concerned about the well-being of a child or young person.

The purpose of the notification duty is to ensure that the municipality is informed of children and young people who may be in need of special support.

It follows from the Social Services Act that when a municipality receives a notification it must assess no later than 24 hours afterwards whether the health or development of the child or young person is at risk and whether there is consequently a need to initiate immediate measures regarding the child or young person. In addition, the municipality must ensure that all notifications are assessed in a timely and systematic manner in order to clarify whether the child or young person is in need of special support.

Furthermore, the municipality shall record the notifications centrally in order to sustain the planning of the measures.

ENHANCED DUTY OF NOTIFICATION
Public-sector employees and others with public duties have an enhanced duty of notification.

This professional staff must notify the municipality if they are made aware or have reason to assume that a child or young person under the age of 18 *may have need of special support*.

GENEREL DUTY OF NOTIFICATION
All citizens have a general notification duty.

Anyone who becomes aware that a child or a young person under the age of 18 is being exposed to *neglect* or any other circumstances which are endangering the development and health of the child or the young person have a duty to notify the municipality.

3.2. Extent

3.2.1. The visits uncovered that there is generally an awareness of the duty to notify the municipality of children and young people who may be in need of special support.

Most institutions had sent one or more notifications to the municipality about specific children or young people, and a number of institutions had sent many notifications.

There were also instances where a municipality which a child or young person moved from notified the municipality which the child or young person moved to. Through such an inter-municipal notification, the municipality which the child or young person moves to is made aware of the needs of the child or young person and can thereby step in with support for the child or young person as early as possible.

On that basis the visits do not give grounds for assuming that – generally speaking – notification is not given when there is occasion for it.

3.2.2. Several accommodation facilities cooperated closely with the placing municipalities about the individual children and young people. Such a cooperation can be of vital importance to safeguarding the best interests of the child but the impression from the monitoring visits is also that a close

cooperation can carry a risk of reluctance to give notification in situations where notification should be given.

The notification duty applies regardless of a close cooperation with the municipality. Consequently, notification regarding a child or young person cannot be omitted, even though the accommodation facility cooperates closely with the municipality concerning the child or the young person.

The issue was discussed in connection with a number of monitoring visits to accommodation facilities.

The Ombudsman will discuss the issue with the Ministry of Social Affairs and the Interior.

3.3. Measures taken on the basis of notification

The Ombudsman asked the institutions to state what measures the notifications had given rise to.

There were notifications which resulted in for instance a move to another asylum centre or to placement at an accommodation facility, and there were notifications which did not lead to any action being taken.

Some asylum centres housed children and young people with a street-oriented behaviour. These are typically young males who are moving around Europe and who are staying for short periods of time at the various centres. They are often substance abusers and can be difficult to reach with motivation and possible treatment. According to information received, just arranging a child consultation with a child or young person with street-oriented behaviour can be difficult, and the group is hard to handle in the municipal system, among other things because these individuals either disappear or do not wish to have contact with the authorities.

In a few cases, the Ombudsman has contacted the municipality about specific notifications in order to learn what action the municipality has taken in consequence of the notification. In one case the municipality would initiate a child protection examination, while the young person in another case was moved to another asylum centre which the municipality agreed to.

3.4. Notification of disappeared or absentee young persons

In connection with a visit to a asylum centre for children the Ombudsman became aware that the centre does not send notifications to the municipality if the young person – about whom there is in the centre's opinion a duty to notify – disappears or stays away from the centre before the notification is sent.

Reportedly, in these cases the centre completes the notification but only sends it to the municipality when and if the young person returns to the centre. This means that a number of notifications are not sent.

In the visiting team's understanding, the reason for this practice is that it is not possible for the municipality to initiate any measures regarding the young person when this individual has disappeared or stays away.

The Ombudsman has questioned the Immigration Service about the described practice, including the fact that a young person has disappeared or stays away in itself can lead to a notification of the municipality. The case is still pending.

4. Health

4.1. The rules

The child has a right to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. So says the UN Convention on the Rights of the Child.

In general, children seeking asylum have the same right to preventive health care and health care services as resident children.

4.2. Access to health care and management of medication in accommodation facilities

During the visits to asylum centres for children and accommodation facilities the Ombudsman examined the access of the children and young people to health care services and the management of medication which is of great importance to the patient safety of the children and young people.

The Ombudsman asked all the institutions for a copy of their instruction on the management of medication and for an account of the organisation of the children and young people's access to health care. During the visits the visiting teams asked additional questions, and they were typically also shown the medicine cabinet.

The Ombudsman did not give any recommendations to the *asylum centres for children* regarding access to health care or about management of medication.

Conversely, most *accommodation facilities* were recommended to ensure that the management of medication is carried out in accordance with the existing rules. The shortcomings were for instance that there was no name and no personal identification number on the medicine locker of the individual

young person and that the medication management instruction among other things did not concern medicine that was administered according to need. One accommodation facility had no medication management instruction at all.

On that basis the Ombudsman makes a general recommendation that accommodation facilities ensure that management of medication takes place in accordance with existing rules.

The Ombudsman has discussed the management of medication in accommodation facilities with the Ministry of Health.

In addition, the Ombudsman will discuss the issue with the Ministry of Social Affairs and the Interior.

4.3. Substance abuse treatment

Several institutions face challenges with children and young people who are substance abusers of for instance alcohol, cannabis or other narcotics.

In connection with the monitoring visits the Ombudsman obtained descriptions of the substance abuse treatment available at the institutions.

The substance abuse treatment could for instance be motivational, and there could be talks with for instance a substance abuse therapist or health care staff.

One institution measured the effect of the substance abuse treatment, and this showed that the institution had a high success rate. At another institution it was unclear how efficient the substance abuse treatment was.

A short – and typically unknown – time frame for the child's or young person's stay was a challenge in connection with the substance abuse treatment. To give an example, one institution had access to a substance abuse treatment centre but the measure did not work very well. This was because of the short time frame for the child's or young person's stay at the institution, combined with non-cooperation on the part of the child or young person.

At another institution the primary problem was that the young people disappeared before the treatment had started. Here as well, however, it was a challenge to motivate the young person to have substance abuse treatment. The young people had a great wish to get treatment but they were not stable enough for it.

The information the visiting team received on substance abuse treatment at the institutions visited varied. One institution expressed its satisfaction with

the treatment which had worked well, while the visiting team was informed at another institution that too little was done with regard to substance abuse, that substance abuse treatment should be put in place earlier, that the access to treatment should be easier and that the young people should receive help immediately.

Substance abuse in children and young people is a serious and worrying problem.

The Ombudsman has discussed the issue of substance abuse treatment with the Ministry of Health and will also discuss it with the Ministry of Social Affairs and the Interior and the Immigration Service.

4.4. Record-keeping and exchange of health information

A patient record documents, among other things, the treatment which the patient has received. This ensures documentation of relevant information about the patient, just as the patient record ensures that this information can be exchanged when and if there is a need for it. In this way, the patient record also helps to ensure treatment continuity.

During a monitoring visit to an asylum centre for children it turned out that information about the children and the young people and their health was recorded in five different places (Planner4U, a separate medical record, LetAsyl, EG Clinia and a physical case file with a health record which the young people often handed in).

The fragmentary structure of the patient record information had the result that the centre did not have a total overview of the young people's background, including any traumatisation and medical, asylum-related and social circumstances.

On that background, the record-keeping could carry the risk that the centre did not act on a sufficiently informed basis but primarily reacted to day-to-day events and thereby neglected to take measures directed at more fundamental problems.

The Ombudsman will discuss the record-keeping and the exchange of health care information between the asylum centres with the Immigration Service. In that context, the Ombudsman will among other things discuss what information should be passed on and retrieved when a child or a young person moves from one centre to another, what rules apply to record keeping and exchange of information, and whether there is a need to give guidance to the centres on the subject.

In another children's asylum centre, the health care staff only had contact with the representative who was provided for the young person according to the Aliens Act to safeguard his or her interests, if that representative contacted them. Furthermore, the representatives at the centre said themselves that they lacked information about the young people.

On that basis the Ombudsman recommended that the centre ensure that a representative pursuant to the Aliens Act – in accordance with the operator contract – is informed of all matters relating to the unaccompanied minor of which custodial parents are normally informed so that the representative has the information necessary to carry out his or her tasks regarding the minor.

When a representative is informed of, among other things, the young person's health conditions, the representative can also help ensure the continuity of treatment.

5. Education

5.1. Education programme and lack of hope

The child has a right to education. This follows from the UN Convention on the Rights of the Child.

The children and the young people attended for instance asylum school, in-house school at the asylum centre or introductory class in the Danish Folkeskole (the State/municipal school). The schools were not included in the monitoring visits but the Ombudsman obtained information about the curriculum offered to the children and young people because education is vitally important to the development of children and young people and their possibility of moving on with life.

There were challenges in several centres with children and young people who had lost hope and belief in a future in Denmark as a result of being refused a residence permit. This meant challenges with particularly a lack of motivation, dreams of the future, possibilities and aims for a better life. The visiting teams witnessed this issue both in asylum centres and in accommodation facilities.

The lost hope of a future in Denmark could for instance make it difficult to create a meaningful everyday life for the young people and to motivate them in connection with school, network and leisure interests in the Danish society. In one institution, some of these young people were awake at night, ate very little, and isolated themselves. In another institution a young person was exempted from education for the first 90 minutes of the morning because the

young person slept very badly at night after being refused a residence permit, and therefore found it difficult to get up in the morning.

5.2. Supervision of in-house schools at asylum centres for children
During two monitoring visits to asylum centres for children, the Ombudsman was informed of the young people's schooling at the centres' in-house schools.

On that basis the Ombudsman has on his own initiative asked the Immigration Service to state how and how often inspection is carried out of whether education in, among others, the in-house schools live up to the rules and when the most recent inspection of the schools' teaching has taken place.

The Ombudsman has also asked the Immigration Service to state whether and if so how the Service follows up on inspection. The case is pending.

5.3. Use of force in in-house schools at asylum centres for children
In schools, including in-house schools at asylum centres for unaccompanied under-age foreign nationals, situations may arise where it is necessary to use force in relation to the pupils.

Based on monitoring visits to asylum centres for children, the Ombudsman has asked the Immigration Service to clarify what rules apply for a possible use of force at in-house schools at the asylum centres for children. The case is pending.

Jørgen Steen Sørensen

6. Appendices

6.1. Overview of institutions visited as part of the theme

When	Where	What
31 Jan. to 1 Feb.	Børnecenter Tønder	Asylum centre for unaccompanied underage foreign nationals
5 Feb. to 6 Feb.	Alhambra, Ballerup	Private accommodation facility for, i.a., children and young people with an asylum background
5 March to 6 March	Fonden Hugin og Munin, Aalestrup	Private accommodation facility for, i.a., children and young people with an asylum background
5 and 7 March	Ask4US ApS, Farsø	Special accommodation facility for unaccompanied underage foreign nationals with a behaviour not compatible with an ordinary asylum centre for minors
10 April to 11 April	Børnecenter Gribskov, Græsted	Asylum centre for unaccompanied underage foreign nationals, including unaccompanied foreign nationals under 16 with a street-oriented behaviour
24 April	Afdelingen for uledsagede mindreårige udlændinge i Center Sandholm, Birkerød	Asylum centre for unaccompanied underage foreign nationals of at least 16 years with street-oriented behaviour
14 May to 15 May	Poseidon, Hurup Thy	Private accommodation facility for children and young people with an asylum background
15 May to 16 May	Mind-move ApS (Busters Verden), Sabro	Private accommodation facility for children and young people with an asylum background
30 Oct. to 31 Oct.	Sortemosevej, Hjortshøj, (**unannounced** visit)	Private accommodation facility for, i.a., children and young people with an asylum background

6.2. The Ombudsman's work with themes

Themes for monitoring activities
Every year, the Ombudsman selects one or more themes for the year's monitoring visits, in cooperation with the Danish Institute for Human Rights and DIGNITY – Danish Institute Against Torture.

The choice of themes is particularly dependent on which areas are in need of an extra monitoring initiative. The Ombudsman will often select a narrow theme, such as for instance the Prison and Probation Service's use of security cells. Other times, the Ombudsman will select broad themes, such as for instance children and young people who, due to a substantial and permanent impairment of their physical or mental function, attend or reside at an institution.

The themes give the Ombudsman the opportunity to include current topics in his monitoring activities and also to make in-depth and transverse investigations of particular problematic issues and to gather experience about practice, including best practice.

A principle aim of any year's monitoring visits is to shed light on and investigate the year's themes. The majority of the year's monitoring visits will therefore go to institutions where the themes are relevant.

Thematic reports
At the end of the year, the Ombudsman, together with the Danish Institute for Human Rights and DIGNITY – Danish Institute Against Torture, reports on the outcome of the year's monitoring activities.

The themes are especially reported in separate reports on the individual themes. In these reports the Ombudsman sums up and imparts the most important results of the themes.

General recommendations
Results of the themes may be general recommendations to the authorities, such as for instance a recommendation to draw up a policy for the prevention of violence and intimidation between the users/residents.

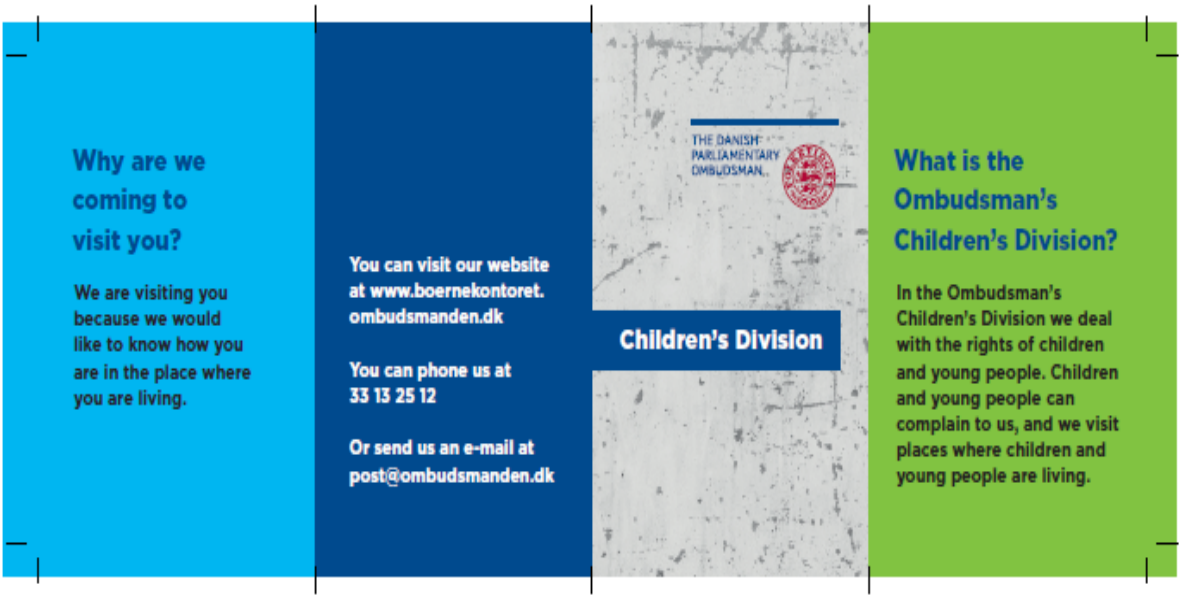
General recommendations are based on the Ombudsman's experience of the field in question. Usually, they will also have been given as concrete recommendations to particular institutions during previous monitoring visits.

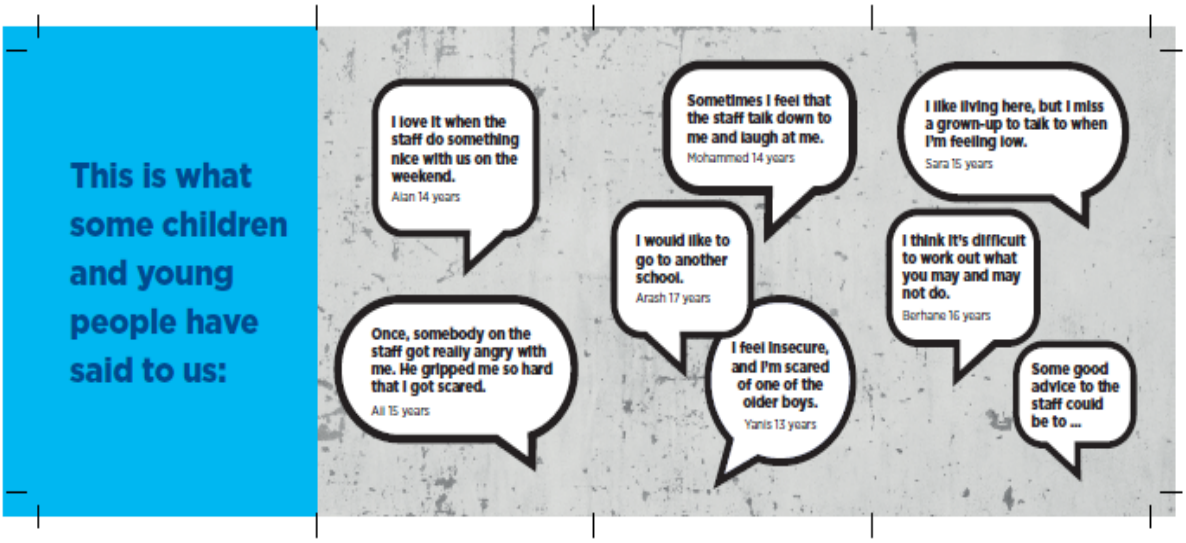
Typically, the Ombudsman will discuss the follow-up to his general recommendations with the central authorities. In addition, the Ombudsman will follow up on the recommendations during monitoring visits.

The general recommendations have a preventive aim. The basis for the preventive work in the monitoring field is that the Ombudsman has been appointed national preventive mechanism (NPM) according to the Optional Protocol to the UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.

The thematic reports are published on the Ombudsman's website, www.ombudsmanden.dk. In addition, the Ombudsman sends the reports to all relevant authorities so that the authorities can include the reports in their deliberations regarding the various sectors. The Ombudsman also informs the Danish Parliament, Folketinget, of the reports.

6.3. Folder


Why are we coming to visit you?
We are visiting you because we would like to know how you are in the place where you are living.
You can visit our website at www.boernekontoret.ombudsmanden.dk
You can phone us at 33 13 25 12
Or send us an e-mail at post@ombudsmanden.dk
THE DANISH PARLIAMENTARY OMBUDSMAN
Children's Division
What is the Ombudsman's Children's Division?
In the Ombudsman's Children's Division we deal with the rights of children and young people. Children and young people can complain to us, and we visit places where children and young people are living.


This is what some children and young people have said to us:
I love it when the staff do something nice with us on the weekend.
Alan 14 years
Once, somebody on the staff got really angry with me. He gripped me so hard that I got scared.
Ali 15 years
Sometimes I feel that the staff talk down to me and laugh at me.
Mohammed 14 years
I would like to go to another school.
Arash 17 years
I feel insecure, and I'm scared of one of the older boys.
Yanis 13 years
I like living here, but I miss a grown-up to talk to when I'm feeling low.
Sara 15 years
I think it's difficult to work out what you may and may not do.
Borhane 16 years
Some good advice to the staff could be to ...

6.4. Check-up form on the use of physical force in accommodation facilities

FOLKETINGETS OMBUDSMAND

Form on the use of physical force in accommodation facilities

Institution, including any specific unit: _____

Age of the child or the young person at start of the use of force: ____

Name of the child or the young person: _____

In general		
Has the standard form of Order 1707/2016, app. 1 a, been used	☐ Yes	☐ No
Have the mandatory blue boxes been (largely) filled in	☐ Yes	☐ No
Have the voluntary green boxes been (largely) filled in	☐ Yes	☐ No

The intervention			
Physical use of force: ..... ☐	*Duration:* ____ *hours* ____ *minutes*		
Does the description give grounds for doubt about the lawfulness of the intervention, including proportionality?	☐ Yes	☐ No	☐ Unclear
If yes, state reasons briefly _____			
Has the intervention been sufficiently documented?	☐ Yes	☐ No	☐ Unclear

Inclusion of the child or young person

Has the child or the young person been informed about the report? ☐ Yes ☐ No ☐ No info

Has the child or the young person had the opportunity to comment on the episode? ☐ Yes ☐ No ☐ No info

Has the child or the young person commented on the episode? ☐ Yes ☐ No ☐ No info

Has a solution been found on how the use of force can be avoided in future? ☐ Yes ☐ No ☐ No info

Does the inclusion of the child or the young person give grounds for other comments? ☐ Yes ☐ No

State reasons briefly _____

_____

Recording and reporting

Has the episode been recorded in the report form "within 24 hours"? ☐ Yes ☐ No ☐ No info

Has a copy of the report form been sent to the placing municipality "without unfounded delay"/"within 24 hours after recording"? ☐ Yes ☐ No ☐ No info

Has the custodial parent been informed "without unfounded delay"/ "immediately after recording"? ☐ Yes ☐ No ☐ No info

Has a copy of the report form been sent to the social supervision authority "by the end of the month"? ☐ Yes ☐ No ☐ No info ☐ Not relevant

Has the intervention been reported to the school municipality? ☐ Yes ☐ No ☐ No info ☐ Not relevant

NOTE: Special rules apply on recording and reporting an action which may be subject to (public) prosecution.

Best interest of the child			
Has the best interest of the child been a primary concern when using force, including in relation to the inclusion of the child or the young person?	☐ Yes	☐ No	☐ Unclear
Briefly state reasons for reply _____			

Other remarks

6.5. Check-up form on the use of physical force in asylum centres for children

FOLKETINGETS OMBUDSMAND

Form on use of physical force in asylum centres

Institution, including any specific unit: _____

The age of the child or the young person at start of the use of force: ____

The name of the child or the young person: _____

In general

Does the report form give cause for comment ☐ Yes ☐ No

If yes, state reasons briefly _____

_____

The intervention

Physical use of force: ..... ☐ *Duration:* ____ *hours* ____ *minutes*

Does the description give grounds for doubt about the lawfulness of the intervention, including proportionality? ☐ Yes ☐ No ☐ Unclear

If yes, state reasons briefly _____

_____

_____

Is the intervention sufficiently documented? ☐ Yes ☐ No ☐ Unclear

Inclusion of the child or the young person

Has the child or the young person been informed about the report?	☐ Yes	☐ No	☐ No info
Has the child or the young person had the opportunity to comment on the episode?	☐ Yes	☐ No	☐ No info
Has the child or the young person commented on the episode?	☐ Yes	☐ No	☐ No info
Has it been ensured that the child or the young person understands what has been recorded on the report form?	☐ Yes	☐ No	☐ No info
Has the child or the young person requested and been given a translation of the most important elements?	☐ Yes	☐ No	☐ No info
Has a solution been found on how the use of force can be avoided in future?	☐ Yes	☐ No	☐ No info
Does the inclusion of the child or the young person give grounds for other comments?	☐ Yes	☐ No	

State reasons briefly _____

_____

_____

_____

_____

Recording and reporting

Has the episode been recorded in the report form "within [24 hours"?](#) ☐ Yes ☐ No ☐ No info

Has a copy of the report form been sent to the Immigration Service "without unfounded delay"? ☐ Yes ☐ No ☐ No info

Has the representative of the child or the young person been informed "without unfounded delay"? ☐ Yes ☐ No ☐ No info

Has a copy of the report form been sent to the social supervision authority "by the end of the month"? ☐ Yes ☐ No ☐ No info ☐ Not relevant

Has the municipal operator been informed "by the end of the month"? ☐ Yes ☐ No ☐ No info ☐ Not relevant

Note: Special rules apply on recording and reporting of an act which is subject to criticism, including a potential criminal liability.

Best interest of the child

Has the best interest of the child been a primary concern when using force, including in relation to the inclusion of the child or the young person? ☐ Yes ☐ No ☐ Unclear

Briefly state reasons for reply _____

_____

Other remarks